Supreme Court, U.S.
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No.

# In the Supreme Court of the United States

OCTOBER TERM, 1994

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

*v.*

HEALTH INSURANCE ASSOCIATION OF AMERICA, INC., AND BLUE CROSS AND BLUE SHIELD ASSOCIATION

## PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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## QUESTIONS PRESENTED

1. Whether the court of appeals erred in invalidating two regulations central to the implementation by the Secretary of Health and Human Services of 42 U.S.C. 1395y(b)(2) (Supp. IV 1992), which provides that Medicare shall provide only secondary insurance coverage for beneficiaries who are eligible for benefits under private insurance plans.

2. Whether the court of appeals erred in holding that courts should accord less deference to an agency's formal interpretive rules in cases involving conduct predating the issuance of those rules.

II

## PARTIES TO THE PROCEEDINGS

In addition to the parties listed in the caption, Bruce C. Vladeck, Administrator of the Health Care Financing Administration, was a party in the courts below and is a petitioner in this Court.

## TABLE OF CONTENTS


| | Page |
|---|---|
| Opinions below | 1 |
| Jurisdiction | 1 |
| Statutory and regulatory provisions involved | 2 |
| Statement | 3 |
| Reasons for granting the petition | 14 |
| Conclusion | 30 |
| Appendix A | 1a |
| Appendix B | 41a |
| Appendix C | 70a |
| Appendix D | 71a |
| Appendix E | 72a |


## TABLE OF AUTHORITIES

Cases:


| | |
|---|---|
| *Bowen* v. *Georgetown Univ. Hosp.*, 488 U.S. 204 (1988) | 25 |
| *Burlington Truck Lines, Inc.* v. *United States*, 371 U.S. 156 (1962) | 25 |
| *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984) | 13, 14 |
| *Clark-Cowlitz Joint Operating Agency* v. *FERC*, 826 F.2d 1074 (D.C. Cir. 1987), cert. denied, 485 U.S. 913 (1988) | 24 |
| *Harper* v. *Virginia Dep't of Taxation*, 113 S. Ct. 2510 (1993) | 24 |
| *Martin* v. *OSHRC*, 499 U.S. 144 (1991) | 25 |
| *Mohasco Corp.* v. *Silver*, 447 U.S. 807 (1980) | 18 |
| *NLRB* v. *Bell Aerospace Co.*, 416 U.S. 267 (1974) | 24, 25 |
| *National Medical Enterprises, Inc.* v. *Sullivan*, 916 F.2d 542 (9th Cir. 1990), cert. denied, 500 U.S. 917 (1991) | 27 |
| *Provident Life & Accident Ins. Co.* v. *United States*, 740 F. Supp. 492 (E.D. Tenn. 1990), appeals dismissed, 925 F.2d 1465, 1466 (6th Cir. 1991) | 18, 28 |

Cases—Continued: Page

*Thomas Jefferson Univ.* v. *Shalala*, 114 S. Ct. 2381 (1994) ..... 17, 23
*United States* v. *Blue Cross & Blue Shield of Michigan*, 726 F. Supp. 1517 (E.D. Mich. 1989) ..... 18, 28
*United States* v. *Mendoza*, 464 U.S. 154 (1984) ..... 27
*United States* v. *Travelers Ins. Co.*, 815 F. Supp. 521 (D. Conn. 1992) ..... 28
*Utah Power & Light Co.* v. *ICC*, 764 F.2d 865 (D.C. Cir. 1985) ..... 27
*Young* v. *Community Nutrition Inst.*, 476 U.S. 974 (1986) ..... 20

Statutes and regulations:

Medicare and Medicaid Amendments of 1980, Pub. L. No. 96-499, Tit. IX, § 953, 94 Stat. 2647 ..... 5
Medicare and Medicaid Amendments of 1981, Pub. L. No. 97-35, Tit. XXI, § 2146, 95 Stat. 800-801 ..... 5
Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, Div. B, Tit. III, 98 Stat. 1061:
§ 2301, 98 Stat. 1063 ..... 6
§ 2344, 98 Stat. 1095-1096 ..... 6
Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, Tit. IX, § 9201, 100 Stat. 170-171 (1986) ..... 7
Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9319, 100 Stat. 2010-2013 ..... 7
Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106:
§ 6202(a)(1), 103 Stat. 2225-2228 ..... 7
§ 6202(a)(1)(A), 103 Stat. 2226 ..... 20
§ 6202(a)(2), 103 Stat. 2228-2229 ..... 7
§ 6202(a)(2)(A), 103 Stat. 2229 ..... 20
§ 6202(b)(1), 103 Stat. 2229-2232 ..... 7
§ 6202(b)(2), 103 Stat. 2233 ..... 7
Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4203(a), 104 Stat. 1388-107 ..... 8

Statutes and regulations—Continued: Page

Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13561(a)(2)(C), 107 Stat. 593 ..... 8
Social Security Act, Tit. XVIII, 42 U.S.C. 1395 *et seq* ..... 4
42 U.S.C. 1395y (Supp. IV 1992) ..... 12, 72a
42 U.S.C. 1395y(b) (Supp. II 1965-1966) ..... 5
42 U.S.C. 1395y(b) (Supp. IV 1980) ..... 5, 6
42 U.S.C. 1395y(b) (Supp. IV 1992) ..... 2, 7, 8, 12, 19, 72a
42 U.S.C. 1395y(b)(1) (Supp. II 1984) ..... 6
42 U.S.C. 1395y(b)(1) (Supp. IV 1992) ..... 7, 72a
42 U.S.C. 1395y(b)(2) (Supp. V 1981) ..... 5
42 U.S.C. 1395y(b)(2) (Supp. IV 1992) ..... 2, 12, 15, 16, 17, 18, 74a
42 U.S.C. 1395y(b)(2)(A) (Supp. IV 1992) ..... 15, 16, 74a
42 U.S.C. 1395y(b)(2)(A)(i) (Supp. IV 1992) .. 2, 12, 16, 75a
42 U.S.C. 1395y(b)(2)(B) (Supp. II 1984) ..... 6
42 U.S.C. 1395y(b)(2)(B) (Supp. IV 1992) ..... 3, 9, 16, 75a
42 U.S.C. 1395y(b)(2)(B)(i) (Supp. IV 1992) .. 3, 10, 12, 16 18, 75a
42 U.S.C. 1395y(b)(2)(B)(ii) (Supp. IV 1992) ... 3, 10, 12, 13 16, 21, 76a
42 U.S.C. 1395y(b)(3) (1982) ..... 6
42 U.S.C. 1395y(b)(3)(A)(i) (Supp. II 1984) ..... 6
42 U.S.C. 1395y(b)(3)(A)(ii) (Supp. II 1984) ..... 6
42 U.S.C. 1395y(b)(4) (Supp. IV 1986) ..... 7
42 U.S.C. 1395y(b)(5) (Supp. IV 1992) ..... 7, 19, 79a
42 U.S.C. 1395y(b)(5)(C)(i) (Supp. IV 1992) ..... 20, 80a
42 U.S.C. 1395hh(a)(1) ..... 4
Social Security Act Amendments of 1994, Pub. L. No. 103-432, § 151, 108 Stat. 4432 ..... 2
Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 116, 96 Stat. 353-354 ..... 6
26 U.S.C. 162(h) (Supp. V 1981) ..... 5
26 U.S.C. 5000 (Supp. IV 1986) ..... 7
26 U.S.C. 5000 (Supp. I 1989) ..... 7
26 U.S.C. 6103(*l*) (Supp. V 1993) ..... 19
26 U.S.C. 6103(*l*)(12) (Supp. V 1993) ..... 7, 19
26 U.S.C. 6103(*l*)(12)(A) (Supp. V 1993) ..... 20
26 U.S.C. 6103(*l*)(12)(C)(i) (Supp. V 1993) ..... 20
28 U.S.C. 1391(e) ..... 28

Statutes and regulations—Continued: Page

29 U.S.C. 623(g) (1982) ..... 6
29 U.S.C. 623(g)(1) (Supp. II 1984) ..... 6
42 C.F.R.:
Section 405.324(a)(3)(iii) (1983) ..... 8
Section 405.327(a)(4) (1983) ..... 8
Section 405.341(c)(1) (1983) ..... 8
Section 405.344(b)(2)(i) (1983) ..... 8
Section 411.24 ..... 4, 9, 10, 12, 13, 15, 18, 20, 28, 82a
Section 411.24(e) ..... 4, 9, 10, 13, 20, 22, 27, 28, 29, 83a
Section 411.24(f) ..... 4, 9, 10, 12, 15, 18, 27, 28, 83a
Section 411.24(f)(1) ..... 4, 10, 83a
Section 411.24(f)(2) ..... 10, 83a
Section 411.24(i)(2) ..... 11, 84a
Section 411.25(a) ..... 11
Section 411.32(a)(1) ..... 11
Section 424.44(a) ..... 16

Miscellaneous:

48 Fed. Reg. (1983):
p. 14,802 ..... 8
p. 14,804 ..... 8
pp. 14,804-14,805 ..... 8
p. 15,902 ..... 8
pp. 15,904-15,905 ..... 8
50 Fed. Reg. 28,992 (1985) ..... 8
53 Fed. Reg. (1988):
p. 22,335 ..... 5, 9
pp. 22,335-22,336 ..... 9
54 Fed. Reg. (1989):
p. 41,716 ..... 9
p. 41,720 ..... 18, 22
H.R. Conf. Rep. No. 386, 101st Cong., 1st Sess. (1989) ..... 19, 20
H.R. Rep. No. 861, 98th Cong., 2d Sess. (1984) ..... 6
H.R. Rep. No. 247, 101st Cong., 1st Sess. (1989) ..... 7, 19
1 S. Rep. No. 494, 97th Cong., 2d Sess. (1982) ..... 6

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## PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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The Solicitor General, on behalf of the Secretary of Health and Human Services and the Administrator of the Health Care Financing Adminstration, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit in this case.

## OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-40a) is reported at 23 F.3d 412. The opinion of the district court (App., *infra*, 41a-69a) is reported at 794 F. Supp. 1166.

## JURISDICTION

The judgment of the court of appeals was entered on May 13, 1994. A petition for rehearing was denied on July 21, 1994. App., *infra*, 70a-71a. On October 17, 1994, the Chief Justice

extended the time within which to file a petition for a writ of certiorari to and including November 16, 1994. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

## STATUTORY AND REGULATORY PROVISIONS INVOLVED

1. Section 1862(b) of the Social Security Act, 42 U.S.C. 1395y(b) (Supp. IV 1992) (as in effect before amendment by the Social Security Act Amendments of 1994, Pub. L. No. 103-432, § 151, 108 Stat. 4432 (signed Oct. 31, 1994)), is set forth at length at App., *infra*, 72a-81a. Section 1395y(b)(2) provides in pertinent part as follows:

**(2) Medicare secondary payer**

**(A) In general**

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—

> (i) payment has been made, or can reasonably be expected to be made, with respect to the item or service [by a primary plan] as required under paragraph (1), or
>
> (ii) payment has been made, or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan

(including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies.

**(B) Conditional payment**

**(i) Primary plans**

Any payment under this subchapter with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this subchapter when notice or other information is received that payment for such item or service has been or could be made under such subparagraph.

**(ii) Action by United States**

In order to recover payment under this subchapter for such an item or service, the United States may bring an action against any entity which is required or responsible under this subsection to pay with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A)[,] collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service.

**(iii) Subrogation rights**

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

2. 42 C.F.R. 411.24 is reprinted in full at App., *infra*, 82a-85a. Section 411.24 provides in pertinent part as follows:

> **§ 411.24 Recovery of conditional payments.**
>
> If a Medicare conditional payment is made, the following rules apply:
>
> * * * * *
>
> (e) *Recovery from third parties.* HCFA has a direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan, or program, and a third party administrator.
>
> (f) *Claims filing requirements.* (1) HCFA may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services.

## STATEMENT

1. The Medicare program provides government health insurance for the aged, the disabled, and persons suffering from end stage renal disease (ESRD). 42 U.S.C. 1395 *et seq.* (1988 & Supp. IV 1992). Congress has charged the Secretary of Health and Human Services with overall responsibility for implementing the Medicare program, and has delegated to her the authority to "prescribe such regulations as may be necessary to carry out [its] administration." 42 U.S.C. 1395hh(a)(1). The Secretary has delegated direct responsibility for the Medicare program to the Administrator of the Health Care Financing Administration (HCFA).

From its inception in 1965 until 1980, Medicare generally acted as the primary insurer for all covered services rendered to eligible beneficiaries. That is, Medicare was the payer of first resort, even where the beneficiary might also have been eligible for payment under private insurance or an employee benefit plan. See generally 53 Fed. Reg. 22,335 (1988). The sole exception was set out in 42 U.S.C. 1395y(b) (Supp. II 1965-1966), which provided that Medicare was not to pay for any item or service "to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations)," under any state or federal workers' compensation scheme. Any Medicare payment was to be "conditioned on reimbursement * * * when notice or other information is received that payment * * * has been made under such a law or plan." *Ibid.*

Beginning in 1980, in response to burgeoning expenditures, Congress enacted a series of amendments now known collectively as the Medicare Secondary Payer (MSP) program. The MSP amendments were designed to reduce Medicare's obligation to make primary payment for covered services. In 1980, Congress added automobile, liability, and no-fault insurance plans to those required to make primary payment under Section 1395y(b).[1] In 1981, new provisions required available private insurance to make primary payment for certain patients suffering from ESRD, and barred tax deductions for employer group health plans (EGHPs) that provided lesser coverage to such patients.[2] In 1982, further amendments required that EGHPs provide primary coverage

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[1] Medicare and Medicaid Amendments of 1980, Pub. L. No. 96-499, Tit. IX, § 953, 94 Stat. 2647; 42 U.S.C. 1395y(b) (Supp. IV 1980).

[2] Medicare and Medicaid Amendments of 1981, Pub. L. No. 97-35, Tit. XXI, Subtit. B, § 2146, 95 Stat. 800-801; 42 U.S.C. 1395y(b)(2) (Supp. V 1981); 26 U.S.C. 162(h) (Supp. V 1981).

for the "working aged," initially defined as employed individuals (and their covered spouses) between the ages of 65 and 69.[3] Congress anticipated that the 1982 amendments would reduce Medicare expenditures by approximately $1.5 billion in the first three years alone. See 1 S. Rep. No. 494, 97th Cong., 2d Sess. 16-17 (1982).

In 1984, Congress broadened the "working aged" amendments to include spouses aged 65 through 69, even if the employed individual was younger.[4] In addition, Congress amended all of the MSP provisions to clarify the Secretary's rights to be subrogated to Medicare beneficiaries' claims against third parties that should have made primary payment, to join litigation against such parties, and to proceed directly against them to recover amounts erroneously paid by Medicare. Specifically, the 1984 amendments added explicit subrogation and direct action provisions to each of the private primary payment requirements in Section 1395y(b), and altered the language of each conditional payment provision to require reimbursement whenever "notice or other information is received that payment for such item or service has been or could be made" under applicable private coverage.[5] In 1986, Congress eliminated the age cap on MSP's "working aged" provisions, and added new provisions covering disabled

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[3] Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 116, 96 Stat. 353-354; 42 U.S.C. 1395y(b)(3) (1982); 29 U.S.C. 623(g) (1982).

[4] Medicare and Medicaid Budget Reconciliation Amendments of 1984 (1984 MMBRA), Pub. L. No. 98-369, Div. B, Tit. III, § 2301, 98 Stat. 1063; 42 U.S.C. 1395y(b)(3)(A)(i) (Supp. II 1984); 29 U.S.C. 623(g)(1) (Supp. II 1984).

[5] 1984 MMBRA § 2344, 98 Stat. 1095-1096; 42 U.S.C. 1395y(b)(1), (2)(B) and (3)(A)(ii) (Supp. II 1984); see H.R. Rep. No. 861, 98th Cong., 2d Sess. 1329-1330 (1984).

Medicare beneficiaries classified as "active" and covered by large EGHPs.[6]

In 1989, Congress reorganized the MSP provisions to consolidate into one provision (42 U.S.C. 1395y(b) (Supp. IV 1992)) the separate subsections dealing with different categories of affected beneficiaries.[7] Section 1395y(b)(1) now provides that certain private medical insurance or benefit plans may not discriminate, on the basis of Medicare eligibility, against the working aged, active employees with disabilities, or certain persons with ESRD. In addition, the 1989 amendments authorized an interagency information-sharing system, known as "Data Match," to permit HCFA access to information from the Internal Revenue Service and the Social Security Administration for any year after 1986, for the purpose of identifying Medicare beneficiaries potentially affected by the MSP provisions.[8] The Data Match

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[6] See Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, Tit. IX, § 9201, 100 Stat. 170-171 (1986) (eliminating age limit on MSP for working aged); Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9319, 100 Stat. 2010-2013 (MSP for disabled employees); 42 U.S.C. 1395y(b)(4) (Supp. IV 1986); 26 U.S.C. 5000 (Supp. IV 1986).

[7] See Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), Pub. L. No. 101-239, § 6202(b)(1), 103 Stat. 2229-2232. OBRA 1989 was enacted on December 19, 1989, two months after the promulgation in final form of the regulations at issue in this case. OBRA 1989 also imposed an excise tax on employers maintaining health benefit plans not in conformity with MSP requirements. OBRA 1989 § 6202(b)(2), 103 Stat. 2233; 26 U.S.C. 5000 (Supp. I 1989).

[8] OBRA 1989 § 6202(a)(1) and (2), 103 Stat. 2225-2229 (codified at 26 U.S.C. 6103(*l*)(12) (Supp. V 1993), and 42 U.S.C. 1395y(b)(5) (Supp. IV 1992)); see H.R. Rep. No. 247, 101st Cong., 1st Sess. 1022-1023 (1989).

provisions were extended by Congress in 1990 and 1993, and now extend through the year 1998.[9]

2. In 1983, the Secretary promulgated regulations designed to implement the statutory MSP provisions that had been enacted since 1980. See 48 Fed. Reg. 14,802 (1983) (liability and no-fault insurance and ESRD provisions); *id.* at 15,902 (working aged provisions). Those regulations made clear, among other things, the Secretary's position that Section 1395y(b) overrides private contractual provisions that purport to limit benefits in a manner contrary to the statute's MSP requirements. See 42 C.F.R. 405.327(a)(4), 405.341(c)(1) (1983); see also 48 Fed. Reg. 14,802, 14,804-14,805 (1983) (stating that Medicare is not bound by contractual provisions that limit insurance coverage to cases in which "timely notice has been given to insurers"); see also *id.* at 15,904-15,905. The regulations also reflected the Secretary's position that Section 1395y(b) implicitly provided HCFA with an independent right to recover conditional payments. See 42 C.F.R. 405.324(a)(3)(iii), 405.344(b)(2)(i) (1983); 48 Fed. Reg. 14,804 (1983). That position was confirmed by Congress in 1984. See page 6, *supra*. In a "general notice" published in the *Federal Register* to provide public guidance concernng a variety of 1984 amendments affecting its programs, HCFA noted that it was now expressly authorzed to sue "[a]ny entity responsible for payment" under the MSP provisions. 50 Fed. Reg. 28,992 (1985).

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[9] See Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), Pub. L. No. 101-508, § 4203(a), 104 Stat. 1388-107; Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), Pub. L. No. 103-66, § 13561(a)(2)(C), 107 Stat. 593. Section 4203 of OBRA 1990 and Section 13561 of OBRA 1993 also made other changes in the MSP provisions, including extensions of the duration of required primary coverage for ESRD patients and the effective date of required primary coverage for active disabled employees.

On June 15, 1988, HCFA proposed a comprehensive revision of the MSP regulations. See 53 Fed. Reg. 22,335 (1988). The proposal responded to a number of intervening statutory amendments, including those enacted in 1984, and recounted HCFA's continuing difficulty in securing MSP compliance. *Id.* at 22,335-22,336. After receiving and responding to extensive public comments, HCFA promulgated final regulations on October 11, 1989. See 54 Fed. Reg. 41,716 (1989). The regulations were designed to clarify the MSP requirements and provide a practical framework for cooperative implementation of the statutory MSP framework by HCFA, beneficiaries, health care providers, and those obligated to make primary payment under the Act.

3. Respondents are two trade associations representing a large proportion of the private health insurance industry in the United States. The 74 Blue Cross and Blue Shield organizations that are members of respondent Blue Cross and Blue Shield Association (BCBS) play a number of roles, issuing individual and group health insurance policies and serving as third-party administrators for self-insured employer health plans. App., *infra*, 41a-42a; C.A. App. 33-34 (BCBS Complaint). Respondent Health Insurance Association of America, Inc. (HIAA) is an association of more than 300 commercial health insurance companies that enter into a variety of contractual arrangements with employers and other sponsors of group health plans. App., *infra*, 42a.

Respondents filed separate actions challenging various provisions of the 1989 MSP regulations and seeking declaratory and injunctive relief. At issue here are respondents' challenges to subsections (e) and (f) of 42 C.F.R. 411.24. Section 411.24 addresses the subject of recovery by the Secretary of those Medicare payments that are made "conditional" by 42 U.S.C. 1395y(b)(2)(B) (Supp. IV 1992).

Subsection (e) of 42 C.F.R. 411.24 notes HCFA's direct right of action against any entity responsible for making

primary payment under the Act (see 42 U.S.C. 1395y(b)(2)(B)(ii) (Supp. IV 1992)), and explains that that category includes "an employer, an insurance carrier, plan or program, and a third party administrator." "Third-party administrators" (TPAs) are typically insurance companies retained by large employers that fund some or all of their own health care benefit plans (rather than purchasing health insurance for their employees); such employers hire outside experts to handle the administrative aspects of the plan, including reviewing, adjusting, and paying beneficiaries' claims. Respondents challenged Section 411.24(e)'s inclusion of TPAs among those from whom the United States may seek direct recovery under the statutory authorization to recover from "any entity which is required or responsible under this subsection to pay" primary benefits. 42 U.S.C. 1395y(b)(2)(B)(ii) (Supp. IV 1992).

Subsection (f)of 42 C.F.R. 411.24 provides that, pursuant to the Secretary's statutory authority to seek reimbursement of Medicare's payment for any item or service for which payment "has been or could be made" under a private plan (see 42 U.S.C. 1395y(b)(2)(B)(i) (Supp. IV 1992)), "HCFA may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim." 42 C.F.R. 411.24(f)(1). The regulation further states as a matter of policy, however, that HCFA will not pursue payment in the face of a claims-filing limitation under an insurance plan unless HCFA has requested reimbursement by the end of the year following the year in which it receives notice of the third party's primary payment obligation. 42 C.F.R. 411.24(f)(2).

The district court consolidated respondents' cases and considered them together on cross-motions for summary judgment. App., *infra*, 41a-42a. The court first reviewed the history of the MSP program (*id.* at 43a-47a) and noted the deferential standard of review appropriate for agency

regulations interpreting an Act of Congress that the agency administers (*id.* at 47a-49a). The court then considered each of the challenged provisions in turn, and concluded that the statutory interpretations on which they were based were either compelled by the Medicare Act or permissible constructions of its terms. *Id.* at 50a-55a.[10] Finally, the court rejected (*id.* at 61a-66a) HIAA's argument that the regulations in question would be impermissibly "retroactive" if applied to any period prior to their promulgation. The court reasoned that the regulations have no impermissible retroactive effect, because they do not impair rights or expectations vested under prior law or regulations. Rather, they "reflect HCFA's current reasonable interpretation of the MSP statute and are designed to give present effect to the statute." *Id.* at 62a, 65a-66a.

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[10] Both respondents also challenged 42 C.F.R. 411.24(i)(2), which provides that if a third party makes payment to a beneficiary or provider when it knows or should know that Medicare has already made a conditional payment for the same item or service, the third party will be required to reimburse Medicare directly if the beneficiary or provider does not do so within 60 days of receiving the third party's payment. In addition, respondent BCBS (but not respondent HIAA) challenged 42 C.F.R. 411.32(a)(1), which provides that Medicare benefits are secondary to other benefits even when an insurance contract or state law provides to the contrary; BCBS objected to that regulation insofar as it might transform so-called "Medigap" policies, which supplement Medicare by covering otherwise unreimbursable expenses (such as Medicare deductibles), into comprehensive primary coverage policies. See App., *infra*, 18a. Finally, HIAA (but not BCBS) challenged 42 C.F.R. 411.25(a), which requires any third-party payer to notify Medicare whenever it "learns that HCFA has made a Medicare primary payment for services for which the third party payer has made or should have made primary payment." See App., *infra*, 20a. The district court rejected respondents' challenges to those regulations (*id.* at 55a-61a), and the court of appeals affirmed (*id.* at 10a-14a, 18a-23a).

4. The court of appeals reversed the district court's judgment with respect to the issues presented here. The court first held that subsection (f) of 42 C.F.R. 411.24 is invalid to the extent that it does not subject the Secretary's independent right to bring a direct action against a primary plan to all the terms (including claims-filing deadlines) applicable to a beneficiary under the insurance plan. App., *infra*, 14a-17a. Although the court recognized (*id.* at 16a) that inclusion of both subrogation and direct right of action provisions in Section 1395y indicated that Congress intended the Secretary to have rights in addition to those of the beneficiary under a primary plan, it read the language of the statute to preclude direct actions in cases in which a claim was not filed within the time limits imposed by such a plan. The court concluded that if Medicare did not make its payment until after the private policy's claims deadline had passed, payment could no longer "reasonably be expected to be made" under the private plan within the meaning of subparagraph (A)(i) of Section 1395y(b)(2), so that neither Section 1395y(b)'s prohibition on payment by Medicare nor its provisions permitting recovery of conditional payments would apply. App., *infra*, 17a. On the other hand, the court reasoned that if Medicare made a conditional payment within the claims-filing deadline of the private plan, but did not seek reimbursement until after that deadline had passed, the plan would no longer be an entity "required or responsible * * * to pay" for the services within the meaning of subparagraph (B)(ii) of Section 1395y(b)(2), which authorizes a direct action by the United States; and private payment no longer "could be made" within the meaning of subparagraph (B)(i), which renders Medicare payments conditional upon subsequent recovery. The court therefore held (App., *infra*, 17a) that Section 1395y(b)(2) should not be construed to provide for recovery by Medicare when the demand for reimbursement was made after passage of a filing deadline applicable to claims under a private plan,

even though the private plan was obligated by the Act to provide primary coverage in the first place.

Two members of the panel also joined, on different grounds, to invalidate Subsection (e) of 42 C.F.R. 411.24 insofar as it construes Section 1395y(b)(2)(B)(ii) to provide for a direct action by the United States against a third-party administrator. App., *infra*, 5a-10a, 32a-35a. Judge Williams agreed with the government (*id.* at 7a) that the statutory language could be read to apply to TPAs, but argued that HCFA had not shown that its "policy judgmen[t]" to adopt that construction was "necessary to accomplish Congress's goals." *Id.* at 8a, 10a. He therefore concluded that the agency's interpretation did not represent a "reasonable policy choice" (*id.* at 8a) within the meaning of *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 845 (1984). Judge Henderson concurred in the result on this point, but on the ground that the statutory language was plain and "the agency is not free to interpret * * * [it] at all." App., *infra*, 34a. Chief Judge Mikva dissented from the ruling on direct actions against TPAs, agreeing with Judge Williams and the government that the statutory text is ambiguous, but finding the administrative interpretation embodied in the regulation "reasonably calculated to effectuate the statute's underlying purpose," and thus entitled to deference under *Chevron*. *Id.* at 36a-38a.

Finally, the majority concluded that two of the regulations it upheld were interpretive rather than legislative rules, but nevertheless held that when an agency seeks to invoke such rules in litigation (rather than in administrative adjudications), they are entitled to no judicial deference in cases involving conduct that predated their issuance. App., *infra*, 23a-31a. Chief Judge Mikva concurred in that holding on somewhat different grounds. *Id.* at 38a-39a.

## REASONS FOR GRANTING THE PETITION

The court of appeals has invalidated, as beyond the Secretary's statutory authority, two regulations that are central to the practical implementation of a major congressional cost-containment initiative affecting the extraordinarily complex and costly Medicare program. The decision presents important legal issues warranting review by this Court: It ignores this Court's instructions to examine the overall statutory framework in assessing the reasonableness of the Secretary's interpretation of the relevant statutory provisions; it rests in critical part on a novel principle of judicial review (requiring an agency to establish a practical "necessity" for its statutory interpretation) that is inconsistent with *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984); and it erroneously bars the "retroactive" application of an administrative interpretation of statutory provisions if that interpretation was announced by rulemaking rather than through agency adjudication.

By bringing this facial challenge to the regulations on behalf of their members (which comprise the bulk of the health insurance industry in the United States), respondents have sought to preempt the Secretary's ability to institute administrative demand proceedings—and, if necessary, independent suits—to recover from individual commercial insurers and Blue Cross/Blue Shield organizations that were obligated by the Medicare Secondary Payer (MSP) provisions to furnish primary coverage. The result has been to all but eliminate the prospect of further litigation in other venues that might generate a circuit conflict. If allowed to stand, the decision below will frustrate efforts by the Secretary to implement the MSP provisions in the manner Congress contemplated by instituting the Data Match program, to recover for the Medicare Trust Funds what HCFA estimates

to be hundreds of millions of dollars in payments for which insurance plans are responsible under the Act, and to confer on those plans a windfall of like proportions. Review by this Court is therefore warranted.

1. The court of appeals erred in invalidating subsection (f) of 42 C.F.R. 411.24, which provides that where primary payment of a covered expense should have been made by a private plan under federal law, Medicare may recover its payment of that expense from the responsible plan without regard to the plan's internal claims-filing deadlines.

a. The court based its decision exclusively on the verb tenses Congress used in various statutory phrases that Section 411.24(f) interprets. App., *infra*, 16a-17a. The court's analysis fails even on its own terms, because the court's construction of the particular statutory provisions on which it narrowly focused is not the only grammatically reasonable one. The court relied, for example, on the fact that subparagraph (A) of 42 U.S.C. 1395y(b)(2) (Supp. IV 1992) prohibits payment by Medicare when payment by a primary plan "can reasonably be expected to be made." See App., *infra*, 17a. That paragraph refers, however, to the time when Medicare is initially called upon to pay a claim—a time when the Medicare intermediary responsible for paying claims might be entirely unaware that the claimant has other insurance coverage. Even at that time, an insurance plan that is under a statutory obligation might "reasonably be expected" by the Medicare intermediary to make payment in the end, if facts establishing the plan's obligation to do so later become apparent. But even assuming that the Act requires private payment only if it "can" still be made under the terms of a private plan (rather than if it "can reasonably be expected to be made" under the terms of the Act) at the time Medicare is first called upon to make payment, subparagraph (A) does not speak to the central issue in this case: whether Medicare may *recover* that payment later, when it learns of insurance

coverage by a primary plan that should have made the payment in the first place.[11]

The time when Medicare receives notice of private primary coverage is the focus of subparagraph (B) of Section 1395y(b)(2). Clause (i) of that subparagraph specifies that any Medicare payment that should have been made by a private plan is "conditioned on reimbursement" by that plan once Medicare receives "notice or other information" that private payment "has been or could be made." The panel emphasized (App., *infra*, 17a & n.6) Congress's use of "could be" rather than "could have been" in clause (i), as well as the fact that clause (ii) of Section 1395y(b)(2)(B) allows the government to recover from a private party that "is," rather than "would have been," required to pay.

The court's reasoning assumes its conclusion. Whether payment "could be" or "is required" to be made under the private plan depends in part on whether the plan's statutory obligation to make primary payment overrides its own internal claims-filing requirements. Indeed, subparagraph (B)(i) of Section 1395y(b)(2) refers to notice of the fact that payment "could be made" not "under the terms of such private plan," but "*under such subparagraph*" (emphasis added), which is to say under subparagraph (A) of Section 1395y(b)(2). Subparagraph (A)(i) in turn refers to payment "as required under paragraph (1)"—the statutory mandate of primary coverage. Thus, the interlocking provisions of Section

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[11] In any event, the court's observation is largely academic. Medicare itself generally requires that claims be filed by the end of the year following the year of service. See 42 C.F.R. 424.44(a). Moreover, a good deal of the practical problem posed by the MSP system and this case stems from the tendency of providers to bill Medicare first, which they have every incentive to do promptly. Thus, in the vast majority of cases, Medicare claims will be submitted and paid by Medicare before the expiration of any private plan filing deadline.

1395y(b)(2) on which the court of appeals relied do not suggest an intent to enable a primary plan to avoid its statutory obligation to pay by invoking its own internal claims-filing deadlines.

In any event, the court's grammatical analysis is at best inconclusive. While Congress could certainly have foreclosed the issue by referring to payments that either "could have been made" or "can still be made" under the terms of the private plan, the language Congress actually used is ambiguous on the question. Such ambiguities should be resolved by reference to the overall structure and purpose of the statute, and with deference to the Secretary's interpretation. See, *e.g.*, *Thomas Jefferson Univ.* v. *Shalala*, 114 S. Ct. 2381, 2386-2387 (1994).

b. The court of appeals' interpretation of Section 1395y(b)(2) is belied by the remainder of the statutory scheme, which relies on Medicare's ability to recover payments that should have been made by primary private coverage. As the court of appeals recognized (App., *infra*, 16a), Congress provided a direct statutory right for the United States to recover conditional payments, which is distinct from the government's subrogation to the rights of the individual beneficiary. Having made that point, however, the court ignored its most logical implication: that the independent right of action was intended to free the Secretary from procedural or other incidental limitations that might bar recovery on the beneficiary's own behalf.

That construction of the Secretary's direct right of action permits a practical response to the practical problem that HCFA faces in implementing the statutory MSP restrictions. In most conditional payment cases, Medicare makes the payment precisely because it is unaware, at that time, of the existence of private coverage. The history of the MSP program is largely one of HCFA's efforts to obtain information in order to identify MSP situations—efforts that

inevitably take substantial time. If Medicare is realistically to recover conditional payments in accordance with Congress's intentions for the MSP program, it must have an adequate opportunity to do so after it learns of the existence of primary private coverage.

Subsection (f) of 42 C.F.R. 411.24 properly interprets the Act to accomplish those goals. Under subparagraph (B)(i) of Section 1395y(b)(2), Medicare's right to recover conditional payments accrues only when HCFA receives "notice or other information" about the existence of private coverage. As the Secretary recognized in promulgating Section 411.24(f), however, application of private claims-filing deadlines—which are typically triggered by the date of the medical service—would mean that the statutory right of recovery would often be time-barred before it even accrues. See 54 Fed. Reg. 41,720 (1989); cf. *Mohasco Corp.* v. *Silver*, 447 U.S. 807, 818 n.22 (1980). Given the substantial time necessary in a system as large and complex as Medicare to obtain information about private insurance coverage, application of such time limits could well bar Medicare from recovering reimbursement in most instances in which Congress required that a private plan be the primary payer. In other words, the statutory reading adopted by the panel effectively vitiates the very statutory right of action that Congress took pains to provide.[12]

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[12] Moreover, as other courts have recognized, making the United States' direct right of action subject to the same procedural limitations that would apply in a subrogation action would deprive the direct action provision of independent significance. See *Provident Life & Accident Ins. Co.* v. *United States*, 740 F. Supp. 492, 505 (E.D. Tenn. 1990), appeals dismissed, 925 F.2d 1465, 1466 (6th Cir. 1991); *United States* v. *Blue Cross & Blue Shield of Michigan*, 726 F. Supp. 1517, 1522 (E.D. Mich. 1989). We note that those courts reached that conclusion on the basis of their own reading of the Act's MSP provisions, without reliance on or deference to the regulation at issue here.

c. That conclusion is reinforced by Congress's reenactment and toughening of the MSP statute in 1989—two months after the regulations at issue here were promulgated in final form, and a year and a half after they were published for comment. The 1989 amendments "reorganized and consolidated" the existing MSP provisions. H.R. Rep. No. 247, 101st Cong., 1st Sess. 1023 (1989). The legislative history of those provisions reflects an intent that Medicare recover whenever it learns of primary coverage, with no suggestion that the primary plan could frustrate recovery simply by invoking its own internal claims-filing deadlines.[13] The 1989 amendments also added a new paragraph (5) to Section 1395y(b) and a new paragraph (12) to 26 U.S.C. 6103(*l*) (Supp. V 1993) to establish a program known as Data Match, an elaborate system for sharing information among HCFA, the Social Security Administration, and the Internal Revenue Service for the purpose of "improv[ing] identification and collection of Medicare secondary payer cases." H.R. Rep. No. 247, *supra*, at 1022. The legislative history makes clear that once HCFA identified potential MSP situations through Data Match, Congress intended that "[a]ny overpayments made by Medicare * * * would also be recovered from liable parties according to existing rules governing Medicare Secondary Payer and overpayment recovery." *Id.* at 1023.

The terms and history of the Data Match program demonstrate Congress's understanding that HCFA must frequently recover conditional payments long after the time of

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[13] The Conference Report states that the revision "[p]rovides that any conditional Medicare payment for items or services for which a primary plan or a liability insurance policy or plan (including a self-insured plan) is responsible is conditioned on reimbursement to the appropriate Medicare trust fund *when notice or other information is received that the other policy or plan is primary.*" H.R. Conf. Rep. No. 386, 101st Cong., 1st Sess. 823 (1989) (emphasis added).

coverage. The 1989 amendments directed the IRS to provide taxpayer information "for any specified year after 1986"—even though Data Match was not authorized until late 1989, and presumably could not be implemented until significantly later. Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), Pub. L. No. 101-239, § 6202(a)(1)(A), 103 Stat. 2226 (codified at 26 U.S.C. 6103(*l*)(12)(A) (Supp. V 1993)). Moreover, the amendments specifically envision that the Medicare program would base recovery on third-party coverage after the period of coverage had elapsed. OBRA 1989 § 6202(a)(2)(A), 103 Stat. 2229 (codified at 42 U.S.C. 1395y(b)(5)(C)(i) (Supp. IV 1992) (emphasis added) (Medicare intermediary or carrier shall use Data Match information to contact employer "to determine during what period the employee or the employee's spouse may be (*or have been*) covered under a group health plan of the employer and the nature of the coverage that is *or was* provided under the plan")); 26 U.S.C. 6103(*l*)(12)(C)(i) (Supp. V 1993) (same). H.R. Conf. Rep. No. 386, 101st Cong., 1st Sess. 820-821 (1989).

Enactment of the Data Match system makes clear that Congress understood and approved the existing MSP conditional payment system. See generally *Young* v. *Community Nutrition Inst.*, 476 U.S. 974, 983 (1986). In addition, it is exceedingly unlikely that Congress would have created (and later twice extended, see pages 7-8, *supra*) the elaborate and costly Data Match system if the recoveries that system was intended to facilitate could be frustrated by the claims deadlines of the very private plans whose primary liability Congress was seeking to enforce. The court of appeals' reading of the Act would make Congress's comprehensive approach largely an exercise in futility.

2. The court of appeals also erred in invalidating Subsection (e) of 42 C.F.R. 411.24, which includes TPAs among the entities from which Medicare may recover conditional payments. As both Judge Williams and Chief

Judge Mikva recognized, the pertinent statutory language does not itself resolve that issue.[14] The court reached its result only because Judge Williams concluded further (App., *infra*, 10a) that although the Secretary's construction of that language "would be reasonable" if it were "necessary to accomplish Congress's goals," HCFA had not demonstrated that it would be "hamstrung or even perceptibly inconvenienced" by adopting a different construction. As Chief Judge Mikva pointed out in dissent (*id.* at 38a), that sort of judgment is not one for a reviewing court under *Chevron*.

Judge Williams' opinion also implies that the Secretary's reading of the statutory language is overbroad, because it could theoretically be stretched to reach banks or law firms. App., *infra*, 8a-9a, 10a. But the regulation actually at issue in this case adopts no such strained interpretation: It addresses only the situation of TPAs, whose central role in administering the health benefits provided by many large employers makes them especially appropriate entities from which to seek reimbursement of costs that should have been

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[14] Contrary to Judge Henderson's opinion on the issue (see App., *infra*, 32a-35a), the statutory text does not compel exclusion of TPAs from the scope of the government's reimbursement efforts. The key provision, Section 1395y(b)(2)(B)(ii), confers on the United States a right of action against "any entity which is required or responsible under this subsection to pay" primary benefits. The word "pay" does not invariably carry with it the requirement that a payer bear the ultimate economic expense of a transaction; it is frequently used simply to denote the disbursement of funds. As Judge Williams noted (App., *infra*, 7a), the "plain language" argument ignores Congress's inclusion of persons "required" to pay, not merely those who are "responsible" for doing so. In addition, the plain language argument interpolates the word "ultimately" into the statute as a qualification for the term "responsible."

borne by those employers—and paid by the TPAs—in the first place.[15]

HCFA will face serious difficulties in recovering conditional Medicare payments if it is prohibited from proceeding against TPAs. Because the entities that act as TPAs are usually insurance companies, which process claims in much the same manner "[w]hether serving as the insurer of an [employer plan] or the provider of administrative services,"[16] it is not initially apparent from a particular claim whether the payer was acting in one capacity or the other. See C.A. App. 433-434 (William Zavoina Decl.). Moreover, requiring HCFA to deal with plans or employers directly rather than through TPAs would significantly complicate the process of recovering conditional payments, because one company may serve as the TPA for hundreds of plans. TPAs represent a large and growing segment of health plans, now accounting for the majority of the plans of medium and large employers. See *id.* at 157 (Leonard Wood Aff.); *id.* at 220-221 (Harvie Raymond Decl.). The court of appeals' decision therefore has

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[15] As the Secretary pointed out in promulgating Section 411.24(e), TPAs not only hold themselves out as experts in dealing with the complex requirements imposed on health plans, but in fact operate as the adjudicators and payers of beneficiary claims, conducting all of the day-to-day functions of the plans they administer. 54 Fed. Reg. 41,720 (1989). Respondents themselves have stated that a TPA "typically investigates and adjudicates individual claims" for its plan(s). See C.A. App. 157 (Leonard Wood Aff.); see also *id.* at 220 (Harvie Raymond Decl.) (TPA deals with "assessing and paying health claims").

[16] C.A. App. 206 (Robert Miller Decl.); see also *id.* at 219 (Harvie Raymond Decl.). Moreover, the line between the roles of insurer and TPA is not always clear, because insurance companies offer a complex range of service packages, often including excess insurance if claims under an administered plan exceed a specified amount. *Id.* at 222-223.

very serious practical implications for the implementation of the Act's MSP requirements.

As Chief Judge Mikva recognized in his dissent (App., *infra*, 36a), the Secretary's assessment of the "operational realities" of a system as complex as Medicare is a matter on which the courts should be especially deferential. See also *Thomas Jefferson Univ.* v. *Shalala*, 114 S. Ct. at 2387. Indeed, the disparity in approach between Judges Mikva and Williams goes not only to the evaluation of the Secretary's actions here, but to the proper standard of review of an agency's statutory interpretations under *Chevron*. As the dissent points out (App., *infra*, 38a), an agency fully satisfies the *Chevron* standard by showing that its interpretation is "consistent with the * * * statute's plain language and reasonably calculated to effectuate the statute's underlying purpose." Judge Williams, on the other hand, imposed a further standard of whether the administrative interpretation is, in the court's view, "necessary" to achieve Congress's goals. *Id.* at 10a. That standard has no basis in the law.

3. The court of appeals agreed with the government that two of the regulations the court upheld are "interpretive" rather than "legislative" rules. App., *infra*, 24a-26a. Although the regulations are "more detailed than the statutory scheme" and "resolve some ambiguities in the statute," they do not represent an exercise of delegated legislative authority; rather, the regulations "reflect the Secretary's elucidation of rights and duties created by Congress" when it enacted the underlying statute. *Id.* at 25a. Having correctly analyzed the nature of the regulations, however, the court refused to embrace the logical consequence of its conclusion: If the Secretary's interpretation is a permissible one, then any rights and duties *elucidated* by the regulations are nonetheless *imposed* by the statute itself. Thus, there can be no issue of "retroactivity"

with respect to conduct that took place after the statute's enactment.

The court's contrary conclusion is without merit. The court relied on its observation (App., *infra*, 27a) that while interpretive rules do not impose new obligations, they may "chang[e] the legal landscape" by adopting one of a range of possible interpretations. But an agency's formal interpretation of a statute alters the state of the law no more than a court's construction of the same statute, or the agency's construction of the statute in the course of an administrative adjudication. Both those types of statutory interpretation are typically retroactive, in the sense that they apply to the prior conduct involved in the particular case and to all new and pending cases, regardless of the relative timing of the underlying conduct or transaction. See *id.* at 29a-30a; see generally *Harper* v. *Virginia Dep't of Taxation*, 113 S. Ct. 2510 (1993); *NLRB* v. *Bell Aerospace Co.*, 416 U.S. 267, 292-295 (1974); *Clark-Cowlitz Joint Operating Agency* v. *FERC*, 826 F.2d 1074, 1081-1086 (D.C. Cir. 1987) (en banc), cert. denied, 485 U.S. 913 (1988).

The court acknowledged (App., *infra*, 29a-30a) that it would be wrong to discourage agencies from giving full retroactive effect to interpretive rules in their own adjudications, because that would create a "perverse disincentive" to issue such rules at all. It attempted to distinguish this case, however, on the ground that the MSP scheme "calls upon HCFA to seek recovery * * * through a direct action in court, not through internal administrative adjudications." *Id.* at 30a. That analysis is flawed. First, the process through which HCFA identifies a potential MSP situation, requests further information from the primary payer, and ultimately demands payment of a specified amount resembles an agency "adjudication" for these purposes, resulting as it does in a final agency determination of liability, based on the information available to the agency and its own interpretation

of the governing law. Cf. *Martin* v. *OSHRC*, 499 U.S. 144, 153, 157 (1991) (agency's issuance and defense of citation, based on particular interpretation of regulations, "*is* agency action" reflecting "historical familiarity and policymaking expertise"). Second, this Court has made clear that an agency's choice whether to interpet and elaborate its statutory mandate through rulemaking or through adjudication lies largely within the agency's discretion. See, *e.g.*, *NLRB* v. *Bell Aerospace Co.*, 416 U.S. at 290-295. That discretion should not be abridged by arbitrary distinctions regarding the "retroactive" effect courts will accord to agency interpretations announced in one way rather than the other.

The decision below raises fundamental issues concerning interpretive rules that require clarification by this Court. The court of appeals made clear that it accords some deference to agency interpretations expressed in formal rules, but it reserved the question whether interpretive rules are entitled to the same level of deference as their "legislative" counterparts. App., *infra*, 27a-28a & n.8. The court went on to hold (*id.* at 30a-31a) that it would defer to the rules at issue in this case only as applied to transactions occurring after their promulgation; in litigation involving earlier transactions, the agency's interpretations would carry only "whatever persuasive force they would enjoy if expressed in a brief filed in that litigation." But if an interpretation represents the considered view of the responsible agency—rather than merely "appellate counsel's *post hoc* rationalizations" for agency action, see *Bowen* v. *Georgetown Univ. Hosp.*, 488 U.S. 204, 212 (1988) (quoting *Burlington Truck Lines, Inc.* v. *United States*, 371 U.S. 156, 168 (1962))—then it should be entitled to the same degree of judicial deference whether it is first expressed in an adjudication or in an interpretive rule. And no matter how expressed, the agency's position remains an interpretation of the underlying statute. It thus makes

little sense to speak of "retroactivity" in the context of an interpretive rule, and even less to invite variant judicial interpretations of the statute before and after articulation of the agency's position in a formal rule.

4. a. Resolution of the questions presented is of considerable practical significance to a major federal program. The progressive tightening of the MSP provisions since 1980 demonstrates quite clearly the importance that Congress places on this method of controlling Medicare expenditures and limiting public funding of health benefits for Medicare beneficiaries who have access to private health coverage. The court of appeals, however, has placed unreasonable limits on the Secretary's ability to recover reimbursement for Medicare payments that should have been made by private insurers.

The size and complexity of the Medicare program and the number of variables involved in identifying and pursuing reimbursement claims make it difficult to estimate the precise monetary impact of the decision below. The first phase of the Data Match program, however, which was designed to discover potential coverage overlaps for a period of three years (from 1987 to 1989), identified potential mistaken payments for those (and in some cases earlier and later) years of approximately $3 billion. To date, HCFA contractors implementing Data Match have issued administrative demands for approximately $1.5 billion in reimbursements, and recovered more than $370 million.[17] Based on even conservative estimates of the percentage of the amount demanded that would ultimately be recovered under the Secretary's regulations (and the percentage of that amount

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[17] Some of those recoveries—those that were made voluntarily, rather than through settlement of litigation—have now been called into question by the decision in this case. HCFA has already received demands for repayment of previously recovered amounts.

that could be lost under the court of appeals' decision), HCFA estimates that the costs involved amount to hundreds of millions of dollars. Moreover, because the ongoing Data Match process involves comparing data for past years, some considerable percentage of potentially erroneous payments identified by intermediaries and carriers will inevitably relate to claims for which a private plan deadline has already passed. Invalidation of Section 411.24(f)therefore presents a serious threat to the effectiveness of the entire Data Match effort, in obvious contravention of Congress's intention in enacting it.

b. Review is warranted in this case even though the decision below is the first appellate decision to consider the validity of the regulations at issue and the statutory interpretations they embody. It is not likely to be either practical or efficient to litigate in other circuits the validity of Section 411.24(f) or the application of Section 411.24(e) to TPAs. HCFA informs us that respondents between them represent the bulk of the private health insurance industry, including the majority of significant TPAs. Respondents brought the present declaratory action on behalf of their members, presumably to achieve a single nationwide resolution of the issues involved, and they may be expected to argue in the future that all of their members are entitled to the benefit of the decision below and whatever relief may be entered if the court of appeals' decision is not reversed.[18]

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[18] We express no view on the proper scope of injunctive or other equitable relief in this case, or on its appropriate collateral estoppel effects. Compare, *e.g.*, *Utah Power & Light Co.* v. *ICC*, 764 F.2d 865, 871 (D.C. Cir. 1985) (trade association members in privity for purposes of collateral estoppel) with *National Medical Enterprises, Inc.* v. *Sullivan*, 916 F.2d 542, 545-546 (9th Cir. 1990) (taking strict view of privity in context of Medicare litigation), cert. denied, 500 U.S. 917 (1991); cf. *United States* v. *Mendoza*, 464 U.S. 154 (1984) (prohibiting use of non-mutual collateral estoppel against the government). At a minimum, however, those issues

Moreover, any potential defendant in the remainder of the industry would be free to seek a declaratory judgment against the Secretary in the District of Columbia. See 28 U.S.C. 1391(e). If not reversed, the decision below would of course control the outcome of any such action.

Two other actions presently pending in district courts in the Second and Sixth Circuits involve the same issues under Sections 411.24(e) and (f).[19] We are informed, however, that there is some possibility that both cases may be resolved. HCFA has proposed resolutions that would include both monetary recovery and the gathering of information that should facilitate better administration of the MSP program in the future. It would be inadvisable for HCFA to forgo otherwise prudent resolutions of those cases simply in order to preserve the opportunity to litigate the legal issues on appeal in other circuits, and then in this Court.

Respondent BCBS's affiliate in Indiana was for some reason expressly excluded from the representative scope of BCBS's complaint (see App., *infra*, 42a n.1), and so is presumably not entitled to any direct benefit of the judgment in this case. There are also insurers and TPAs that are not, or were not at some relevant time, members of either respondent organization. And the validity of Subsection (f) of Section 411.24 (but not Subsection (e)) presumably could be raised in

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would require additional costly and time-consuming litigation in any future action involving these issues with any of respondents' members.

[19] See *United States* v. *Blue Cross & Blue Shield of Michigan*, 726 F. Supp. at 1521-1522 (granting summary judgment to the government on claims limitation issue, but to Blue Cross on TPA issue); *United States* v. *Travelers Ins. Co.*, 815 F. Supp. 521 (D. Conn. 1992) (same result on TPA issue). See also *Provident Life & Accident Ins. Co.* v. *United States*, *supra* (same result as in *BCBS Michigan*; case ultimately settled, resulting in a $27 million recovery for the government).

litigation brought directly against self-insuring employers, rather than against their insurers or TPAs. In the meantime, however, the Secretary would be subject to a decision that will significantly interfere with her administration of the MSP program and require her to forgo significant recoveries that Congress has mandated and to which the Medicare Trust Funds are entitled under a proper interpretation of the Act.

In short, in light of the portion of the industry represented by respondents in this suit and the availability of the District of Columbia as a forum for other such suits, the prospects for a meaningful opportunity to litigate the questions presented in this case in other circuits are limited and speculative. Pursuing that course would, in any event, be a lengthy and comparatively inefficient process, and there is no reason to believe that that process would result in any significant sharpening or clarification of the issues. Under these circumstances, we submit that there is no reason for the Court to postpone consideration of the important questions presented by this case.

c. Two aspects of the decision below also have much broader potential significance for the relationship between courts and administrative agencies. First, the court struck down Section 411.24(e) even though two judges agreed that the statutory language was ambiguous, and that the agency's interpretation of that language was plausible. That mistaken approach to judicial review of agencies' statutory interpretations threatens to disrupt settled principles of review under *Chevron*. Second, the court's discussion of the "retroactivity" of interpretive rules reveals a fundamental misapprehension of the nature of such rules and of the deference to which they are entitled from the courts. Both those errors take on added significance coming, as they do, from a court that hears a disproportionate number of cases involving federal agencies' interpretations of the statutes they are charged with administering. Taken together with

the significant administrative disruption and public costs that will result from the court of appeals' judgment in this case, those errors warrant further review.

## CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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NOVEMBER 1994

APPENDIX A

# UNITED STATES COURT OF APPEALS
# DISTRICT OF COLUMBIA CIRCUIT

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Nos. 92-5196, 92-5197

HEALTH INSURANCE ASSOCIATION OF AMERICA, INC.,
APPELLANT

v.

DONNA E. SHALALA, SECRETARY, HEALTH AND HUMAN SERVICES, ET AL.,
APPELLEES

BLUE CROSS AND BLUE SHIELD ASSOCIATION,
APPELLANT

v.

DONNA E. SHALALA, SECRETARY, HEATH AND HUMAN SERVICES, ET AL.,
APPELLEES

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Argued Oct. 29, 1993

Decided May 13, 1994

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Before: MIKVA, CHIEF JUDGE, WILLIAMS and HENDERSON, CIRCUIT JUDGES.

Opinion for the Court filed by Circuit Judge WILLIAMS.

Concurring opinion filed by Circuit Judge HENDERSON.

Opinion concurring in part and dissenting in part by Chief Judge MIKVA.

STEPHEN F. WILLIAMS, Circuit Judge:

The appellants in these two consolidated cases raise facial challenges to five Medicare regulations promulgated by the Health Care Financing Administration ("HCFA") on behalf of the Secretary of Health and Human Services. They also contend that even if the regulations are valid, the Secretary is attempting to give improper retroactive effect to four of them. In a comprehensive opinion, the district court upheld all five regulations and rejected the appellants' retroactivity arguments. *Blue Cross & Blue Shield Ass'n v. Sullivan*, 794 F.Supp. 1166 (D.D.C.1992). We affirm in part. We conclude that two of the five regulations go beyond the Secretary's statutory authority and hence are invalid. We also disagree with the district court's retroactivity analysis.

## I. The Statutory Framework

Medicare is a system of federally funded health insurance for the aged, the disabled, and people suffering from end-stage renal disease. Many people covered by Medicare are also eligible for benefits under group health plans provided by employers. For its first fifteen years, Medicare paid for services without regard to whether they were also covered by an employer group health plan. As a cost-cutting measure, however, Congress eventually enacted a

series of amendments designed to make Medicare a "secondary" payer with respect to such plans. These amendments have been codified at 42 U.S.C. § 1395y(b), which is referred to as the "Medicare as Secondary Payer" ("MSP") statute.

The structure of the MSP statute is relatively simple. Paragraph (1) imposes certain requirements on employer group health plans.[1] A nondiscrimination provision, for instance, insists that plans other than those provided by small employers must provide the same benefits under the same conditions to aged employees (and to aged spouses of employees) as to other employees and spouses. 42 U.S.C. § 1395y(b)(1)(A)(i)(II) (Supp. IV 1992). In addition, when someone age 65 or older is covered by an employer group health plan by reason of his current employment (or the current employment of his spouse), the plan "may not take into account" that his age entitles him to Medicare benefits. *Id.* § 1395y(b)(1)(A)(i)(I). The effect of this is to nullify any plan provision that would "carve out" expenses covered by Medicare and thus, in effect, make the plan's coverage secondary to Medicare's.[2] Somewhat

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[1] An employer group health plan is "any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of such employees or former employees". 42 U.S.C. § 1395y(b)(1)(A)(v); 26 U.S.C. § 5000(b)(1).

[2] Thus the Fifth Circuit was not technically correct when it said that "the MSP statute has never created or extended coverage; it has only dictated the order of payment when Medicare beneficiaries already have alternate sources of payment for health care." *Blue Cross & Blue Shield of Texas v. Shalala*, 995 F.2d 70, 73 (5th Cir.1993). While the MSP statute certainly does not require employers to offer group health plans to their employees, it does impose requirements

similar provisions deal with people suffering from end-stage renal disease. See *id.* § 1395y(b)(1)(C). With exceptions not relevant here, large group health plans also "may not take into account" that an employee or a member of his family is entitled to Medicare benefits by reason of disability. *Id.* § 1395y(b)(1)(B).

Paragraph (2) then makes Medicare the "secondary" payer with respect to coverage required under paragraph (1), and spells out the means by which that purpose is to be realized. Subparagraph (A) prohibits Medicare from making any payment, other than a conditional one, for any item or service to the extent that "payment has been made [under a group plan], or can reasonably be expected to be made [under a group plan], with respect to the item or service as required under paragraph (1)". *Id.* § 1395y(b)(2)(A)(i). Subparagraph (B) then explains what it means for a payment to be conditional; in a clause headed "Primary Plans",[3] it declares that any Medicare payment under the circumstances described in subparagraph (A) "shall be conditioned on reimbursement to the appropriate Trust Fund ... when notice or other information is received that payment for such item or service has been or could be made under such subparagraph." *Id.* § 1395y(b)(2)(B)(i). In order to recover conditional payments, the next clause continues, "the United States may bring an action against any entity which is required or responsible

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when employers choose to offer such plans. If a plan is written in ways that impermissibly "take account of" beneficiaries' eligibility for Medicare, the MSP statute works to extend the plan's coverage beyond its own terms.

[3] For our purposes, the MSP statute uses the term "primary plans" to mean employer group health plans. *Id.* § 1395y(b)(2)(A).

under this subsection to pay with respect to such item or service (or any portion thereof) under a primary plan. . . ." *Id.* § 1395y(b)(2)(B)(ii). Indeed, when an employer group health plan "fails to provide for primary payment (or appropriate reimbursement) in accordance with . . . paragraphs (1) and (2)(A)", a private party or the federal government can sue for double damages. *Id.* § 1395y(b)(3)(A). In addition, the federal government is subrogated (to the extent of any payment for an item or service to which subparagraph (2)(A) applies) "to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan." *Id.* § 1395y(b)(2)(B)(iii).

## II. The Challenged Regulations

Acting as the Secretary's delegate, HCFA has promulgated regulations to carry out the MSP statute. The appellants, the Health Insurance Association of America and the Blue Cross and Blue Shield Association, both challenge three regulations as going beyond the Secretary's statutory authority, and each challenges one that the other does not attack. All parties agree that we are to uphold each regulation unless it contradicts "the unambiguously expressed intent of Congress" or is not a "reasonable interpretation" of an ambiguous statutory provision. *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837, 842-43, 844, 104 S.Ct. 2778, 2782, 81 L.Ed.2d 694 (1984).

A. *42* CFR § *411.24(e)—third-party administrator liability.*

Both appellants are associations of health-insurance companies whose members often enter into contracts with employers or employer group health plans. Under some of these contracts, the companies

underwrite some or all of the health plan's benefits. Frequently, however, employers self-insure, and hire one of the appellants' member companies merely to perform administrative services such as adjudicating claims and writing benefit checks drawn on accounts stocked with the employer's money. "[A]lthough there are variations in these [administrative-services] contracts," explains amicus curiae the Self-Insurance Institute of America ("SIIA"), "administrators customarily do not pay the financial obligations of their plan customers from their own funds or commingle plan funds with their own funds." Brief of Amicus Curiae SIIA 12 (emphasis in original); cf. Joint Appendix ("J.A.") 290-98 (sample administrative-services contract).

Nonetheless, HCFA believes that these third-party administrators are "required or responsible under [the MSP statute] to pay ... under a primary plan" within the meaning of 42 U.S.C. § 1395y(b)(2)(B)(ii), and hence that they are subject to suit by HCFA for recovery of conditional payments. Though HCFA's regulations did not explicitly take this position until 1989, 42 CFR § 411.24(e) now asserts that "HCFA has a direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan, or program, and a third party administrator." (Emphasis added).

The appellants argue that this regulation contradicts the plain language of the MSP statute, or at any rate represents an impermissible resolution of ambiguities in that statute. They insist that when an insurance company contracts with an employer or an employer group health plan merely to administer the plan, without putting the company's own funds at risk by assuming ultimate financial liability for making

payments under it, HCFA cannot seek recovery from the company for conditional payments, but instead can sue only the employer or the plan itself. Three district courts have agreed. See *United States* v. *Travelers Ins. Co.*, 815 F.Supp. 521, 524 (D.Conn. 1992); *Provident Life & Accident Ins. Co. v. United States*, 740 F.Supp. 492, 503-04, amended, 1990 U.S.Dist. LEXIS 12810 (E.D.Tenn.1990); *United States v. Blue Cross & Blue Shield of Michigan*, 726 F.Supp. 1517, 1521-22 (E.D.Mich.1989).

The essence of the appellants' argument is that HCFA is wrong to equate the statutory phrase "responsible . . . to pay" with the phrase "responsible for making . . . payment". According to Amicus SIIA, "Any common sense reading of the phrase 'responsible to pay' could only mean the party that bears the ultimate financial risk." Brief of Amicus Curiae SIIA at 7 n. 10.

This argument is somewhat weakened by the fact that the statute does not use the word "responsible" alone, but also explicitly encompasses entities "required" to pay insurance benefits. As a matter of pure language, this phrase can be read to focus not on which entities bear the financial risk under a plan, but rather on which entities must fulfill the requirements imposed by a plan. These requirements of course include not only what the employer and employees may have agreed on, but also the substantive enlargements mandated by the MSP statute itself via its nondiscrimination provisions and its bans on "tak[ing] into account" Medicare coverage. Even an entity that merely administers a plan, then, is literally "required" by the MSP statute, coupled with the plan itself and the contract to render administrative services, to pay for services rendered to Medicare beneficiaries under the plan.

There remains, however, the question whether it is "reasonable" to interpret paragraph (2)(B)(ii) to subject such entities to suit. See *Chevron*, 467 U.S. at 843, 845, 104 S.Ct. at 2782, 2783. "As a practical matter, resolution of an ambiguity in a statute, if it has consequences, inevitably requires the agency to consider competing policy objectives", and "it is the reconciliation of such conflicts that is entitled to judicial deference". *Wagner Seed Co. v. Bush*, 946 F.2d 918, 923 (D.C.Cir.1991). In some sense, then, review of an agency's construction of an ambiguous statute is review of the agency's policy judgments. While we are to defer to those judgments, we cannot accept them if they seem wholly unsupported or if they conflict with the policy judgments that undergird the statutory scheme. Thus the Chevron Court upheld the interpretation at issue there only after concluding that it "is a reasonable policy choice for the agency to make". *Chevron*, 467 U.S. at 845, 104 S.Ct. at 2783.

We start the consideration of HCFA's policy claims by considering the potential reach of its linguistic argument for reading the MSP statute to authorize recovery actions against administrators that assume no financial responsibility for paying a plan's benefits. The bank on which a plan's benefit checks are drawn is literally both "required" and "responsible" to pay group insurance benefits when presented with such a check. Cf. U.C.C. § 4-402 (describing banks' liability for wrongful dishonor of checks); *id.* § 4-404 (saying that banks have "no obligation . . . to pay a check, other than a certified check, which is presented more than six months after its date"). In the context of the MSP scheme, however, it would be wholly unreasonable for HCFA to treat the bank as a responsible payer subject to

recovery actions. Third-party administrators obviously present a closer case, but, given HCFA's sketchy theories, perhaps not all that much closer.

Since insurance companies often serve as third-party administrators, the government complains that "Medicare will often not even know, initially, whether the insurer is acting as a [third-party administrator] or as a conventional insurer in a given instance". Appellees' Brief at 31-32. The appellants respond that HCFA need only ask the third-party administrator to direct it to the responsible payer. Appellants' Reply Brief at 12 n. 11. The government suggests that this might be impracticable, because the distinction between insurers and third-party administrators is often "murky" in light of the "highly complex and enormously varied" contracts between outside companies and employer group health plans. Appellees' Brief at 32. For example, insurance companies and employer group health plans sometimes agree that the plan will fund its own benefits up to a specified maximum total each year, and that the insurance company—in addition to providing administrative services—will underwrite benefits once that ceiling is reached. See J.A. 222, 299-301. Under such contracts, it might not be entirely clear whether the employer or the insurance company bears ultimate financial liability for any given item or service. But the existence of contracts under which the financial liability is "murky" seems an odd justification for imposing it on a party who—by perfectly clear contract—is plainly not liable.

The government also suggests that unless third-party administrators face the threat of recovery actions, they will deny the claims of Medicare-eligible employees, knowing that Medicare then will pay primary. According to the government, it is appro-

priate for HCFA to seek recovery from third-party administrators directly because they "are the entities that actually make claims determinations" and are "generally better positioned than self-insured employers to assure the plan's compliance with MSP requirements." Appellees' Brief at 32.

This argument seems a complete jumble. First, the government gives no clue what the third-party administrator would have to gain from exposing its client to liability under the MSP statute—including double damages under § 1395y(b)(3). Second, expertise in traversing the technical underbrush of Medicare and other medical insurance requirements can hardly be the touchstone of liability; under such a view the third-party administrator's law firm might be the best candidate. Finally, HCFA offers no evidence to support its scenario of deliberate evasion by administrators.

Unless HCFA can come up with stronger reasons to support subjecting third- party administrators to recovery actions, we do not think they can reasonably be considered "required or responsible under [the MSP statute] to pay . . . under a primary plan" within the meaning of 42 U.S.C. § 1395y(b)(2)(B)(ii). We agree with HCFA that if such actions were necessary to accomplish Congress's goals, HCFA's construction of the statute would be reasonable. But the record before us does not come close to showing that HCFA will be hamstrung or even perceptibly inconvenienced unless it can proceed directly against administrators.

B. *42* CFR § *411.24(i)—"double payment"*.

The appellants also challenge 42 CFR § 411.24(i), which they have dubbed "the double-payment regulation". Section 411.24(i)(2) applies when a third-party payer which "is, or should be, aware" that

Medicare has already made a conditional primary payment for a covered item or service nonetheless pays an entity other than Medicare—usually the beneficiary, a provider, or a supplier—for that item or service. If the recipient of the third-party payment fails to reimburse Medicare within sixty days, as required under 42 CFR § 411.24(h), then "the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party". 42 CFR § 411.24(i)(1).

According to the appellants, "nothing in the statute . . . requires an insurance company in such a situation to pay Medicare rather than the individual to whom the company is contractually liable, much less pay both." Appellants' Opening Brief at 17-18. Once the company has complied with its contractual duties to reimburse a beneficiary or provider, the appellants insist, it is no longer "responsible . . . to pay . . . under a primary plan" and hence cannot be sued under clause (2)(B)(ii) of the MSP statute. *Id.* at 15.

This conclusion draws some support from the structure of that clause. After providing for direct actions against any entity that is required or responsible to pay under a primary plan, the MSP statute goes on to authorize actions against "any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service". 42 U.S.C. § 1395y(b)(2)(B)(ii). In the absence of other indications, one might infer from these provisions that whenever a third-party payment has been made, the government's direct right of action lies only against its recipient. One district court, without much analysis, has accepted this conclusion. *Provident*, 740 F. Supp. at 504-05.

In asserting the invalidity of 42 CFR § 411.24(i), however, both the Provident court and the appellants have ignored an important element of the MSP statute: the government's subrogation rights. Suppose that a 65-year-old employee's surgery is covered both by Medicare and his employer's group health plan, and that Medicare makes the payment initially. The fact that Medicare has made a payment obviously does not excuse the employer's health plan from paying; paragraph (1) of the MSP statute explicitly forbids the plan to "take account of" the patient's eligibility for Medicare, and thus requires the plan to make the payment that it otherwise would have made. Since "payment . . . can reasonably be expected to be made . . . as required under paragraph (1)," Medicare's payment is conditional. 42 U.S.C. § 1395y(b)(2)(A)(i). And as soon as HCFA makes its conditional primary payment, it is "subrogated . . . to any right under [the MSP statute] of an individual or any other entity to payment with respect to such item or service under a primary plan." *Id.* § 1395y(b)(2)(B)(iii).

Although subrogation law varies from state to state, there are many common features. Suppose a tortfeasor injures a victim, and the victim's insurance company pays his loss and becomes subrogated to his rights against the tortfeasor. Suppose further that the tortfeasor knows of the insurance company's payment (and hence its subrogation rights), but nonetheless deals with the victim directly and obtains a general release from him in exchange for a cash settlement. The victim can no longer proceed against the tortfeasor, but the insurance company generally can—even though it is simply subrogated to the victim's rights. *See, e.g.*, 6A John Alan Appleman & Jean Appleman, Insurance

Law and Practice § 4092, 246-49 & n. 16 (1972 & Supp.1992) (collecting cases); John F. Dobbyn, Insurance Law in a Nutshell 241-42 (2d ed. 1989); 3 Rowland H. Long, The Law of Liability Insurance § 23.04[1], 23-42 (1993) (collecting cases); 16 Ronald A. Anderson, Couch on Insurance § 61:201 (2d ed. 1983 & Supp.1993) (collecting cases). But see *id.* § 61:202 (citing a few contrary cases). In other words, knowing payment by the obligor (tortfeasor) to the wrong party (tort plaintiff) does not bar recovery by the right party (insurer, the right party by virtue of subrogation). The analogy seems quite apt.

To be sure, 42 CFR § 411.24(i) applies when the third-party payer "is, *or should be*, aware" of Medicare's primary payment at the time that it makes its own payment. But in the liability-insurance context, at least one standard treatise explicitly declares that the victim's release does not bar the subrogee's right of recovery from the tortfeasor as long as the tortfeasor obtained the release "with knowledge, actual *or constructive*, of the fact that the insurers have already paid to the insured the amount of their liability to him". *Couch on Insurance* § 61:201 (emphasis added). Court decisions confirm that view. See, e.g., *Gibbs v. Hawaiian Eugenia Corp.*, 966 F.2d 101, 107 (2d Cir.1992) (citing cases).

Given this background, the appellants simply are incorrect that 42 CFR § 411.24(i) represents an improper attempt to extend the MSP statute's double-damage penalties, or to impose liability on entities that are no longer responsible to pay under a plan. If a third-party payer wants to avoid having to make two payments for the same service, it should refrain from

paying someone whom it knows or should know that HCFA already has paid.[4]

We of course do not endorse every possible reading that HCFA may in the future give to the words "should be . . . aware". According to HCFA's Paul J. Olenick, the agency finds this condition met only when the third-party payer "has in its possession direct information that Medicare has made a conditional primary payment or information necessary to draw the conclusion that Medicare has made a conditional primary payment". J.A. 418-20. The latter reference evidently means that HCFA expects third-party payers to draw certain inferences based on published Medicare procedures. For instance, if a third-party payer turns down a claim filed by an aged employee who is eligible for Medicare, Medicare will pay the beneficiary unless the claim was denied for one of four specified reasons. See 42 CFR § 411.75. If the beneficiary later appeals the private payer's denial of his claim and gets it reversed, HCFA expects the private payer to infer that Medicare has made a conditional payment. J.A. 419. We do not have the details of any such transaction before us, and thus pass no judgment on how the regulatory language may work out in application. But we cannot find that the regulation violates the statute.

C. *42* CFR § *411.24(f)—override of claims procedures.*

The final regulation challenged by both appellants is 42 CFR § 411.24(f), which asserts that Medicare

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[4] Of course, a third-party payer that does make such a payment, and then is required to reimburse Medicare under § 411.24(i), can attempt to recover its original payment from the recipient.

can recover conditional payments "without regard to any claims filing requirements that the . . . plan imposes on the beneficiary or other claimant." According to the regulation, then, if HCFA pays for a service that would also be covered under an employer group health plan if the plan's procedures (such as filing deadlines) were observed, HCFA can demand reimbursement from the plan *even if those procedures were not followed.*

In an affidavit filed with the district court, HCFA's Paul J. Olenick disclaimed any intent to seek recovery when the beneficiary violates "a contractual requirement that goes to the essence of the insurance obligation". According to Olenick, requirements for "pre-approval of certain treatments" fall within this class, for "HCFA recognizes the cost-savings implications of these programs and supports them". J.A. 413. The government now relies on this affidavit to conclude that the regulation authorizes HCFA to override only the "routine filing deadlines applicable to plan members", not other plan limitations. Appellees' Brief at 34-35.

As an interpretation of the regulation (rather than as a statement about how HCFA intends to enforce it), this position is absurd. The regulation explicitly mentions "a time limit for notifying the plan . . . about the need for . . . services" as an example of the procedural requirements that HCFA is free to override. 42 CFR § 411.24(f) (1). But for purposes of argument we will suspend our disbelief and treat the government's current position as an authoritative interpretation of the regulation. Even so, we would find the regulation an invalid extension of the MSP statute.

If the regulation has any statutory basis, it springs from HCFA's independent right to recover condi-

tional payments under the first two clauses of paragraph (2)(B) of the MSP statute, not from HCFA's subrogation rights under the third clause. After all, unless the plan has done something to cause the deadline to be missed, it certainly would have a good defense against the claimant who missed the deadline, and hence against any claim by HCFA as subrogee.[5]

The appellants contend that this conclusion ends the matter; they believe that the government's substantive recovery rights stem entirely from the subrogation provision of clause (2)(B)(iii) of the MSP statute. It seems clear, however, that in making certain payments conditional in clause (2)(B)(i) and then creating a direct government right of action to recover them in clause (2)(B)(ii), Congress intended something independent of the subrogation provided for in clause (2)(B)(iii). Indeed, this appears to be the case under a somewhat parallel statute the appellants themselves invoke, 42 U.S.C. § 2651(a). See, e.g., *Commercial Union Ins. Co. v. United States*, 999 F.2d 581, 587 (D.C.Cir.1993) (government right to sue not limited by judgment or settlement obtained by tort victim); *United States v. Theriaque*, 674 F.Supp. 395 (D.Mass.1987) (government's independent right of action entitles it to full recovery even where tort victim's right would be limited by comparative negligence).

Nonetheless, the government's position is not consistent with the language of the particular statute that here creates the independent right of action. Clause (2)(B)(i) provides that any Medicare payment

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[5] In some circumstances, HCFA's subrogation rights might conceivably permit it to seek recovery against the beneficiary, provider, or supplier who let the deadline lapse. This case does not present that question and we do not reach it.

is "conditioned on reimbursement" if it is a "payment under this subchapter with respect to any item or service to which subparagraph (A) applies." Subparagraph (A) in turn embraces payments "with respect to any item or service to the extent that . . . payment [1] has been made, or [2] can reasonably be expected to be made" under the plan. If the beneficiary and provider have already missed the filing deadline by the time Medicare makes its payment, then neither of those two criteria is satisfied, and the authorization of recovery actions in clause (2)(B)(ii) applies only to an "item or service" as to which (2)(B)(i) makes Medicare's payment "conditioned on reimbursement." Moreover, clause (2)(B)(ii)'s own language imposes independent obstacles to HCFA's view. Even if Medicare makes its payment before the plan's deadline passes, so that payment might be "expected to be made" under subparagraph (2)(A), the government's direct right of action lies against "any entity which is required or responsible under this subsection to pay . . . under a primary plan," 42 U.S.C. § 1395y(b)(2)(B)(ii) (emphasis added)—not against an entity that would have been responsible to pay if the beneficiary (or other obligee) had followed the proper procedures. Likewise, HCFA can seek reimbursement from the plan "when notice or other information is received that payment for such item or service . . . could be made" under the plan, *id.* § 1395y(b)(2)(B)(i) (emphasis added)—not (as the district court quoted the MSP statute to say) "when notice or other information is received that payment for such item . . . could have been made" under the plan, see 794 F.Supp. at 1172 (emphasis added).[6]

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[6] The government insists that the district court's misquotation makes no difference, because "the word 'could'

D. *42 CFR § 411.32(a)(1)—"carve out" and "Medigap" restriction.*

Before the district court, Blue Cross/Blue Shield—but not the Health Insurance Association—also challenged 42 CFR § 411.32(a)(1), which provides that "Medicare benefits are secondary to benefits payable by a third party payer even if State law or the third party payer states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries." The appellants concede that the MSP statute nullifies "carve-out" provisions in employer group health plans that purport to reduce or eliminate benefits as a result of coverage by Medicare. But the appellants protest that § 411.32(a)(1), as interpreted by HCFA, treats "Medigap" policies—private insurance contracts that supplement Medicare by covering expenses not covered by the government, such as deductible or coinsurance amounts—like giant carve-outs, effectively transforming them into comprehensive policies.

The statutory analysis that the appellants offer in support of their protest strikes us as confused. Focusing entirely on paragraph (2) of 42 U.S.C. § 1395y(b), the appellants contend that the MSP statute is triggered only when Medicare and an employer health plan provide overlapping coverage,

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may serve as either the past or the present conditional of the word 'can'". Appellees' Brief at 38 n. 22. But "could have been" is different from "could be". Suppose that ten years ago someone had surgery that would have been covered by his health plan if he had filed a timely claim, but that payment from the plan is no longer available because he never filed a claim. Looking back on his misfortune, he might say, "Payment could have been made under the plan if I had filed a claim", but not, "Payment could be made under the plan if I had filed a claim."

and that this situation never arises with "Medigap" policies. Under this argument, however, the MSP statute would not override even what the appellants admit are impermissible carve-outs. The statutory authority for 42 CFR § 411.32(a)(1) must start with paragraph (1) of 42 U.S.C. § 1395y(b), for it is that paragraph that forbids plans to "take account of" certain individuals' eligibility for Medicare.

That said, we confess that the scope of any disagreement between HCFA and the appellants is far from clear to us. The MSP statute and 42 CFR § 411.32(a)(1) deal only with employer group health plans, and so the working aged are free to purchase "Medigap" policies on their own.[7] What is more, the government conceded at oral argument that employer group health plans are free to provide "Medigap" coverage to *retirees* and their spouses. Conversely, the appellants concede that the nondiscrimination provisions of 42 U.S.C. § 1395y(b)(1) preclude employers from offering their Medicare-eligible employees only "Medigap" coverage, while offering comprehensive coverage to their other employees. See Appellants' Reply Brief at 14 n. 13. Blue Cross/Blue Shield's complaint in the district court suggests that its principal concern may be that one of its member companies—in performing its contract with an employer group health plan—will mistakenly provide only "Medigap" coverage for an employee in the belief that he is retired, and will find itself liable

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[7] Contrary to the appellants' suggestion, then, the government is conceding little when it refers to Medigap policies as "a useful form of insurance that many Medicare beneficiaries purchase *individually* in order to secure more comprehensive coverage than that supplied by Medicare alone." See Appellees' Brief at 23 (emphasis added); cf. Appellants' Reply Brief at 14.

for his health-care costs to the full extent of the plan's coverage of other employees. See J.A. 50. But while the appellants alluded to this fear at oral argument, they have not otherwise discussed it on appeal. The affidavit that they cite as revealing HCFA's interpretation of the regulation, moreover, does not give us a clearer sense of what is at stake. See J.A. 517.

We decline to speculate about the factual settings in which HCFA will invoke the regulation. On its face, 42 CFR § 411.32(a)(1) does not appear inconsistent with the MSP statute; indeed, at oral argument the government took the view that the regulation merely restated the substantive requirements of 42 U.S.C. § 1395y(b)(1). To the extent that the regulation restates the MSP statute, we of necessity affirm it; insofar as it may do anything else, we can detect no issue fit for judicial review. Cf. *Abbott Laboratories v. Gardner*, 387 U.S. 136, 148-49, 87 S.Ct. 1507, 1515-16, 18 L.Ed.2d 681 (1967). The appellants may, of course, litigate HCFA's attempts to apply the regulation on a case-by-case basis as warranted.

E. *42* CFR § *411.25(a)—mandatory notice.*

In the district court, the Health Insurance Association—but not Blue Cross/Blue Shield—attacked 42 CFR § 411.25(a), which declares that "[i]f a third party payer learns that HCFA has made a Medicare primary payment for services for which the third party payer has made or should have made primary payment, it must give notice to that effect to the Medicare intermediary or carrier that paid the claim." In contrast to its position on the other four regulations, the government does not see § 411.25(a) as a mere interpretation of the MSP statute; instead, it views the regulation as a legislative rule promul-

gated under the Secretary's authority to "prescribe such regulations as may be necessary to carry out the administration of the insurance programs". 42 U.S.C. § 1395hh(a)(1).

The appellants argue that § 411.25(a) was promulgated in violation of the notice-and-comment procedures required of legislative rules by the Administrative Procedure Act. See 5 U.S.C. § 553(b). It is true that § 411.25(a) was added in response to comments that HCFA received on its proposed rule, and hence appeared for the first time in the final rule. Compare 53 Fed.Reg. 22335 (June 15, 1988) (proposed rule) with 54 Fed.Reg. 41716, 41718 (Oct. 11, 1989) (final rule). But the question for us is whether the final rule is a "logical outgrowth" of the proposals on which the public had the opportunity to comment. *United Steelworkers of America v. Marshall*, 647 F.2d 1189, 1221 (D.C.Cir.1980); *Aeronautical Radio, Inc. v. FCC*, 928 F.2d 428, 445-46 (D.C.Cir.1991); cf. *International Harvester Co. v. Ruckelshaus*, 478 F.2d 615, 632 n. 51 (D.C.Cir.1973).

We think that this test is met here. In explaining the background to its proposed rules, HCFA specifically bemoaned the fact that, in its experience, "many 'Medicare secondary payer' (MSP) claims are not identified for MSP processing". 53 Fed.Reg. at 22335. Underneath a heading that proclaimed HCFA's intention "To Ensure Identification of Other Payers That Are Primary to Medicare", HCFA added: Although the changes in the law have clarified HCFA's ability to recover conditional payments, it is obvious that there can be no recovery without identification of other insurers that are primary to Medicare. We believe that this aspect of the problem must be dealt with in regulations to the maximum extent permitted under current law. *Id.* at 22337.

Likewise, one of HCFA's proposed rules declared that if Medicare makes a conditional payment, "The filing of a Medicare claim by or on behalf of the beneficiary constitutes an express authorization for the third party to release to Medicare an[y] information pertinent to the Medicare claim." *Id.* at 22347. We believe that HCFA's initial notice adequately foreshadowed 42 CFR § 411.25(a).

The appellants also attack the substance of § 411.25(a), asserting that Congress did not intend to let the Secretary require "private monitoring". One might think that the regulation does not call for any such thing, for it is triggered only when a third-party payer "learns" that Medicare has made a primary payment. But according to the declaration of HCFA's Paul Olenick, HCFA interprets the word "learns" in this regulation to mean the same thing as the already discussed phrase "is, or should be, aware" in 42 CFR § 411.24(i)(2), J.A. 419, and considers it to embrace a situation where a third-party payer "receives the information necessary to draw the conclusion that Medicare has made a conditional payment", *id.* at 420. Again, HCFA evidently expects third-party payers to draw some inferences based on Medicare's public procedures.

Although Mr. Olenick's statements suggest that HCFA intends to read "learn" broadly, we review only the regulation; just how far HCFA may stretch the language, under the usual judicial deference to an agency's interpretation of its own regulations, see, e.g., *United States v. Larionoff*, 431 U.S. 864, 872-73, 97 S.Ct. 2150, 2155-56, 53 L.Ed.2d 48 (1977), must await resolution in concrete cases. The regulation, however, seems to us not to go beyond the Secretary's statutory authority. For their claim that it does, the appellants appear mainly to rely on the principle of

expressio unius est exclusio alterius, pointing to specific congressional requirements of notice. Thus, they note that the MSP statute requires the Commissioner of the Social Security Administration to request certain information from the IRS and to disclose information to HCFA that would help identify situations in which Medicare is a secondary payer; it also requires employers to respond to certain inquiries from Medicare intermediaries or carriers. See 42 U.S.C. § 1395y(b)(5)(A) & (C). But the usual vulnerabilities of the expressio unius doctrine, especially in the context of mandates to administrative agencies, see, e.g., *Cheney R.R. Co. v. ICC*, 902 F.2d 66, 68-69 (D.C.Cir.1990), coupled with Congress's explicit delegation of rulemaking authority to the Secretary to aid in administering the Medicare program and the apparent reasonableness of the Secretary's requirement, all undermine the negative inference that the appellants invite us to draw.

## III. Retroactivity

The effective date of the regulations at issue here was November 13, 1989. But with the exception of the notice requirement of 42 CFR § 411.25(a), the Secretary claims the ability to apply the regulations that we have upheld to transactions that occurred prior to that date. The appellants contend that such application would be invalidly retroactive. Each regulation, they say, "creates a new obligation, imposes a new duty, or attaches a new disability in respect to transactions or considerations already past", *Association of Accredited Cosmetology Schools v. Alexander*, 979 F.2d 859, 864 (D.C.Cir.1992) (quoting *Neild v. District of Columbia*, 110 F.2d 246, 254 (D.C.Cir.1940), in turn quoting *Society for Propagating the Gospel v.*

*Wheeler*, 22 F.Cas. 756, 767 (C.C.D.N.H.1814) (Story, J.)), and retroactive rulemaking is beyond the Secretary's power, *Bowen v. Georgetown University Hospital*, 488 U.S. 204, 109 S.Ct. 468, 102 L.Ed.2d 493 (1988).

In *Georgetown Hospital*, the Secretary had issued a rule changing the Medicare program's method for calculating cost limits. Two years later, a federal district court held that the rule had been promulgated in violation of the Administrative Procedure Act. After proper notice and comment, the Secretary readopted the same rule, retroactive to the original date of effectiveness. The Supreme Court unanimously invalidated the Secretary's retroactive action, holding that agencies lack the power to promulgate retroactive legislative rules "unless that power is conveyed by Congress in express terms." *Id.* at 208, 109 S.Ct. at 472.

The government correctly notes that *Georgetown Hospital* involved a "legislative" rule rather than an "interpretive" one and that except for 42 CFR § 411.25(a), all the rules at issue here are interpretive. Though not claiming explicitly that interpretive rules are exempt from the ban on retroactivity, the government insists that interpretive rules are by nature incapable of having retroactive effect; by definition, it says, they merely reiterate what Congress has already said in a pre-existing statute.

We agree with the government—and indeed the appellants do not deny—that the rules whose application is disputed are interpretive. In contrast to the legislative rule at issue in *Georgetown Hospital*, which was promulgated pursuant to a statutory directive calling for cost limits to be determined "in accordance with regulations estab-

lishing the method or methods to be used, and the items to be included, in determining such costs", see 42 U.S.C. § 1395x(v)(1)(A), the MSP rules (other than 42 CFR § 411.25(a)) do not rest on the Medicare Act's delegation of legislative authority to the Secretary; instead, they reflect the Secretary's elucidation of rights and duties created by Congress. *See American Mining Cong. v. Mine Safety & Health Admin.*, 995 F.2d 1106, 1109-10 (D.C.Cir.1993). They obviously are more detailed than the statutory scheme, and they also resolve some ambiguities in the statute. But an interpretation of a statute does not become a legislative rule merely because "it supplies crisper and more detailed lines than the authority being interpreted". Id. at 1112; accord *Caraballo v. Reich*, 11 F.3d 186, 195 (D.C.Cir.1993) ("While we have said that interpretive rules 'cannot go beyond the text of a statute,' we do not, of course, mean to imply that an interpretive statement may only paraphrase statutory or regulatory language. Indeed, a mere paraphrase would hardly be interpretive at all.") (citation omitted). The dividing line, as we said in *American Mining Congress*, is whether implementing regulations are necessary in order to make a statutory scheme fully operative: "[A] rule supplying [necessary legislative] action will be legislative no matter how grounded in the agency's 'understanding of what the statute requires', and an interpretation that spells out the scope of an agency's or regulated entity's pre-existing duty . . . will be interpretive, even if . . . it widens that duty even beyond the scope allowed to the agency under Chevron. . . ." *American Mining Cong.*, 995 F.2d at 1110.

It is true that the MSP rules were published in the Code of Federal Regulations, a fact that American Mining Congress said suggested that the prescribing

agency likely intended them to have "legal effect" and thus that they were likely to be legislative rather than interpretive. See *American Mining Cong.*, 995 F.2d at 1109, 1112; see also 44 U.S.C. § 1510 (limiting publication in CFR to rules "having general applicability and legal effect"); *Brock v. Cathedral Bluffs Shale Oil Co.*, 796 F.2d 533, 539 (D.C.Cir.1986) (invoking the distinction to divide policy statements from rules). In none of the cases citing the distinction, however, has the court taken publication in the Code of Federal Regulations, or its absence, as anything more than a snippet of evidence of agency intent. See *Alaska v. United States Dep't of Transp.*, 868 F.2d 441, 446 (D.C.Cir.1989); *Industrial Safety Equipment Ass'n v. EPA*, 837 F.2d 1115, 1121 (D.C.Cir.1988); *American Hospital Ass'n v. Bowen*, 834 F.2d 1037, 1056 (D.C.Cir.1987); *Community Nutrition Inst. v. Young*, 818 F.2d 943, 947 n. 8 (D.C.Cir.1987); *Telecommunications Research & Action Center v. FCC*, 800 F.2d 1181, 1186 (D.C.Cir.1986). Here, the snippet is not enough.

But the conclusion that the rules at issue here are interpretive does not in itself legitimate their application to prior transactions. We agree with the government's implicit concession that interpretive rules, no less than legislative rules, are subject to Georgetown Hospital's ban on retroactivity. The Administrative Procedure Act's definition of a "rule"—"the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy . . .", 5 U.S.C. § 551(4)—draws no distinction between rules that "interpret" law and rules that "prescribe" law: both must be of "future effect". Cf. *Georgetown Hospital*, 488 U.S. at 216-23, 109 S.Ct. at 476-79 (Scalia, J., concurring).

Where we part company with the government is in its notion that interpretive rules merely echo things "that are already express in the statute". See Appellees' Brief at 48 (emphasis omitted). A rule may be interpretive even though it "interprets" a vague statutory duty or right into a sharply delineated duty or right. *American Mining Cong.*, 995 F.2d at 1112; *General Motors Corp. v. Ruckelshaus*, 742 F.2d 1561, 1564 (D.C.Cir.1984) (en banc); *American Postal Workers Union v. U.S. Postal Service*, 707 F.2d 548, 558-59 (D.C.Cir.1983). Yet the interpretation in a sense changes the legal landscape. Just as a dollar is not exactly the same as a 50-50 chance at two dollars, a precise interpretation is not the same as a range of possible interpretations. Nonetheless, despite the reality of the change, we defer to these agency interpretations.[8] (Indeed, we defer to them even when

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[8] We have often applied Chevron deference to interpretive rules without comment. See, e.g., *General Motors Corp. v. Ruckelshaus*, 742 F.2d 1561, 1565-67 (D.C.Cir.1984). According to *Wagner Seed Co. v. Bush*, 946 F.2d 918, 922 (D.C.Cir.1991), "it simply is not the law of this circuit that an interpretive regulation does not receive the Chevron deference accorded a legislative regulation." But cf. *National Latino Media Coalition v. FCC*, 816 F.2d 785, 788 (D.C.Cir.1987) (dictum quoting *Joseph v. United States Civil Serv. Comm'n*, 554 F.2d 1140, 1154 n. 26 (D.C.Cir.1977), for the proposition that "even though courts often defer to an agency's interpretative rule they are always free to choose otherwise"). Some commentators believe that *Chevron* deference is appropriate only for "legislative" rules, not "interpretive" ones. *See* Robert A. Anthony, "Which Agency Interpretations Should Bind Citizens and the Courts?", 7 Yale J.Reg. 1, 55-58 (1990); cf. Michael Herz, "Deference Running Riot: Separating Interpretation and Lawmaking Under *Chevron*", 6 Admin.L.J. of Amer.U. 187 (1992). Because the parties have agreed that *Chevron* deference is appropriate here, we have no need to address the scope of deference to an interpretive rule. Our conclusions

the agency previously took a contrary view, equally worthy of deference. See, e.g., *Mobil Oil Corp. v. EPA*, 871 F.2d 149 (D.C.Cir.1989).) When courts review agency action, then, an agency armed with an interpretive rule is in better shape than one whose interpretation of a statute might be denigrated as a mere litigating position. See, e.g., *Georgetown Hospital*, 488 U.S. at 212, 109 S.Ct. at 473-74 (citing *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168, 83 S.Ct. 239, 245-46, 9 L.Ed.2d 207 (1962)).

The government's insistence that interpretive rules add nothing to the statutes that they interpret rests largely on *Sentara-Hampton General Hospital v. Sullivan*, 980 F.2d 749 (D.C.Cir.1992) (per curiam). There the plaintiff hospital had sued to obtain reimbursement of an interest expense, after HCFA had largely ruled against it in an agency adjudication conducted under 42 U.S.C. § 1395oo(f)(1). The HCFA decision rested in part on interpretations expressed in a 1983 revision of the Medicare Provider Reimbursement Manual. When the case reached this court, we concluded that the 1983 revisions merely interpreted and clarified the existing regulations, and hence were not invalidated by the Secretary's failure to follow notice-and-comment procedures. We acknowledged that the revisions "probably . . . made it easier for the Secretary to enforce the regulations", *id.* at 759, but—emphasizing that the revisions had merely interpreted the existing rules—we concluded that the hospital "did not suffer from the 'retroactive' application of substantive law". *Id.* at 760 (citing *Georgetown Hospital*).

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about retroactivity, however, would apply as long as courts gave interpretive rules any deference at all.

In the context of judicial review of internal agency adjudication, as in *Sentara-Hampton*, it was not mean-ingful to ask whether the standard that HCFA applied sprang from HCFA's 1983 revisions to the Manual (i.e., its interpretive rule) or from its interpretation of the pre-existing legislative regulations; as the court stressed, there was no difference between the two, for the interpretive rule merely stated HCFA's reading of the old regulations. Even if this reading had been novel, agency interpretations announced in adjudications typically are retroactive, and, subject to some limits, are permissibly so. See generally *Clark-Cowlitz Joint Operating Agency v. FERC*, 826 F.2d 1074, 1081-86 (D.C.Cir.1987) (en banc); *General American Transp. Corp. v. ICC*, 872 F.2d 1048, 1060-61 (D.C.Cir.1989); *see also Georgetown Hospital*, 488 U.S. at 222, 109 S.Ct. at 478-79 (Scalia, J., noting typically retroactive character of adjudication). Since HCFA was already free to subject *Sentara-Hampton* to the standard expressed in its 1983 revisions even in the absence of their promulgation as such, the Sentara-Hampton court correctly held that the interpretive rule itself was not being given retroactive effect. To put it another way, any retroactive effect was completely subsumed in the permissible retroactivity of the agency adjudication.

Indeed, in the context of internal adjudicatory procedures, to hold that agencies can apply their new interpretations of pre-existing statutes or regulations retroactively only if they do not memorialize those interpretations in interpretive rules would create a perverse disincentive to issue such rules. The ironic result would be that the entities affected by the agency's interpretations would be left more in the dark than before, for clues to the agency's reading

of the relevant texts would emerge only on an ad hoc basis. And this even though an ad hoc answer developed in binding agency adjudication would enjoy judicial deference. See, e.g., *Martin v. Occupational Safety & Health Review Comm'n*, 499 U.S. 144, 156-57, 111 S.Ct. 1171, 1179, 113 L.Ed.2d 117 (1991).

Here, however, the statutory scheme calls upon HCFA to seek recovery of conditional payments through a direct action in court, not through internal administrative adjudications. In this context, it is quite meaningful to speak of interpretive rules as having retroactive effect. If the court were to interpret the governing texts in the first instance, unconstrained by an agency interpretation entitled to deference, it might well take a different view of them than the agency. A court that instead defers to interpretive rules promulgated after the transaction at issue is obviously giving those rules retroactive effect.

The government correctly observes that in lieu of promulgating the new MSP rules in 1989, "HCFA could have simply begun bringing lawsuits [seeking recovery of conditional payments under the MSP statute], and left it to the courts to decide these issues without the authoritative guide of published regulations." Appellees' Brief at 48. Exactly so. The point is a good indication that HCFA's rules are interpretive, but it does not mean that when HCFA seeks recovery with respect to transactions that occurred before the effective date of the 1989 rules, it can exploit and claim deference for interpretive rules that did not exist when the transactions were conducted. HCFA certainly can bring suits seeking recovery with respect to such transactions, but when it does so it must proceed directly under the MSP statute and whatever pertinent rules were in effect at

the time of the transactions. The analyses expressed in the interpretive regulations upheld here should be received with whatever persuasive force they would enjoy if expressed in a brief filed in that litigation.

In short, with respect to transactions that occurred before November 13, 1989, HCFA must do precisely what the government proposes: leave it to the courts to make their decisions without deference to the 1989 rules. If the government is correct that the rules add nothing to the MSP statute, then our ruling will be no impediment to the sound implementation of the MSP statute.

## IV. Conclusion

To sum up, we agree with the appellants that 42 CFR §§ 411.24(f) and 411.24(e) go beyond the Secretary's statutory authority and hence are invalid. But we reject the appellants' facial challenges to §§ 411.32(a)(1), 411.25, and 411.24(i). As for the retroactivity issue, we hold that courts cannot award HCFA recovery out of deference to interpretive rules that did not exist when the transactions at issue were conducted. While the Secretary certainly can try to recover for such transactions under the statutory and regulatory provisions in effect at the time, she cannot draw support from interpretive rules adopted thereafter.

Accordingly, the judgment of the district court is *Affirmed in part and reversed in part.*

KAREN LECRAFT HENDERSON, Circuit Judge, concurring:

I join the majority's retroactivity holding as well as its holdings declaring the double payment regulation (42 C.F.R. §411.24(i)), the mandatory notice regulation (42 C.F.R. § 411.25(a)) and the carve out coverage regulation (42 C.F.R. § 411.32(a)(i)) valid and the claims filing regulation (42 C.F.R. § 411.24(f)) and third-party liability regulation (42 C.F.R. § 411.24(e)) invalid. I write separately, however, because I disagree with the majority's analysis of the third-party liability regulation.

HCFA promulgated the regulation setting forth third-party liability, 42 C.F.R. § 411.24(e), as an interpretation of the MSP statute. The majority opinion concludes that the regulation is invalid because it is not a reasonable interpretation of the statute. *Majority Opinion* at 416-17. While I reach the same result, I would invalidate the regulation because it is inconsistent with the plain text of the MSP statute. *See Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43, 104 S.Ct. 2778, 2782, 81 L.Ed.2d 694 (1984).

The MSP statute grants HCFA recourse if it mistakenly pays the health care expenses of an individual covered by both Medicare and an employer group health plan (EGHP). HCFA's erroneous payments are deemed "conditioned on reimbursement," 42 U.S.C. § 1395y(b)(2)(B)(i), if the agency determines that payment for the services "has been or could be made" by a third-party payer pursuant to an EGHP. 42 U.S.C. § 1395y(b)(2)(A)(i). To effectuate HCFA's right of reimbursement, the statute creates a right of action "against any entity which is required or responsible . . . to pay . . . under a primary

plan." 42 U.S.C. § 1395y(b)(2)(B)(ii). HCFA interprets section 1395y(b)(2)(B)(ii) to grant the United States a direct action against "an employer, an insurance carrier, plan, or program, and a third party administrator." 42 C.F.R. § 411.24(e). Its interpretation, however, is inconsistent with the text of the MSP statute because the statute creates a right of action only against those entities "required or responsible ... to pay" health care benefits and a third-party administrator (TPA) does not fall within this category.

A TPA is a company that services an employer with a self-insured health plan. *Amicus Curiae Brief of the Self-Insurance Institute of America* at 10-11. A typical contract between the employer and the TPA obliges the TPA to provide claims-processing and other administrative services to the employer for a fee. See Joint Appendix (J.A.) at 290-98. Customarily, all health care benefits under the EGHP are paid by the TPA from the employer's funds; the TPA does not make any payment with its own money nor does it commingle plan funds with its own funds. *Amicus Curiae Brief of the Self-Insurance Institute of America* at 12. Under its agreement with a self-insured employer, then, the TPA is not "required or responsible" to pay the medical expenses of individuals covered by the EGHP it administers.

Nor does the language of the MSP statute impose a "require[ment]" or "responsib[ility]" on the TPA to pay health care expenses. *See United States v. Travelers Ins. Co.*, 815 F.Supp. 521, 524 (D.Conn.1992) (plain language of statute does not impose additional obligations on TPA); *Provident Life & Accident Ins. Co. v. United States*, 740 F.Supp. 492, 504 (E.D. Tenn. 1990) (plain language of statute creates cause of

action against only those entities with ultimate responsibility for payment); *United States v. Blue Cross & Blue Shield of Michigan*, 726 F.Supp. 1517, 1521-22 (E.D.Mich.1989) (statute's plain text creates right of action only against "those who are responsible to actually make the payments, i.e., the self-insured employer plan itself, and not those who merely undertake to administer the payment process. . . ."). Because the TPA is not obligated to pay health care expenses under either its contract with the employer or the MSP statute and because the right of action created by Congress lies only against an entity obligated to pay, I would invalidate the regulation because it contradicts the "unambiguously expressed intent of Congress." *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43, 104 S.Ct. 2778, 2782, 81 L.Ed.2d 694 (1984).

The majority believes the statute is ambiguous, and thus open to interpretation by HCFA, because it creates a right of action against an entity not only "responsible" to pay but also "required" to pay. It explains that "[t]hese requirements of course include not only what the employer and employees may have agreed on, but also on the substantive enlargements mandated by the MSP statute itself via its nondiscrimination provisions and its bans on 'taking into account' Medicare coverage." Majority Opinion at 416. From this explication it concludes that the TPA is literally required by the MSP statute to pay for services rendered to Medicare beneficiaries under the plan. *Id.* It then goes on to invalidate the regulation as an unreasonable interpretation of the statute. But I reject the majority's statutory exegesis and would instead hold that the agency is not free to interpret the plain meaning of the statutory language at all.

As the majority points out, the MSP statute expressly alters the insurer's obligations to its insured through at least two provisions. *See* 42 U.S.C. § 1395y(b)(1)(A)(i)(I) (EGHP may not take into account employee's eligibility for Medicare); 42 U.S.C. § 1395y(b)(1)(A)(i)(II) (EGHP must provide employee age sixty-five or older with same benefits it provides employee under sixty-five). These provisions, however, do not in any way alter the obligations of the TPA to an employee who is covered by the EGHP it administers. Although the majority points to these two statutory provisions as proof positive that the MSP statute enlarges the TPA's responsibilities, it cannot identify any language in the MSP statute that supports its conclusion. Given Congress's explicit grant of a right of action against only those entities responsible or required to pay—which a TPA plainly is not—and in the absence of any language in pari materia indicating otherwise, I would hold the regulation invalid as contrary to the MSP statute's plain text.[9]

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[9] That the MSP statute plainly intends to allow recovery only from an insurer finds further support in the language of 42 U.S.C. § 1395y(b)(3)(A), which creates a private cause of action for double damages "in the case of a primary plan which fails to provide for primary payment . . . ." *Id.* (emphasis added). This language evidences Congress's intent that only the entity that provides a primary plan incur liability. Congress's use of the term "primary plan" instead of "entity," as in 42 U.S.C. § 1395y(b)(2)(B)(ii), is not consistent with an intent to impose liability on an entity whose duties with respect to the plan are ministerial only.

MIKVA, Chief Judge, concurring in part and dissenting in part:

This court upholds today three of five regulations that the Health Care Financing Administration ("HCFA") promulgated pursuant to the "Medicare as Secondary Payer" ("MSP") statute, 42 U.S.C. § 1395y(b). I dissent from that portion of the majority opinion holding HCFA's third party administrator regulation unreasonable. While I concur in the judgment of the court regarding the impermissible retroactivity of one of the challenged regulations, the reasoning on which I base that judgment differs from that of the majority.

A. *42* C.F.R. § *411.24(e)*: *Third Party Administrator Liability*

The Medicare as Secondary Payer statute authorizes HCFA to recover conditional Medicare payments from "any entity which is required or responsible to pay . . . under a primary plan" for services rendered. 42 U.S.C. § 1395y(b)(2)(B)(ii). HCFA construes this statutory provision to include third party administrators ("TPAs"), companies that administer the payment of health care benefits without assuming financial liability for claims filed. 42 C.F.R. § 411.24(e). The majority holds this regulation to be unreasonable; I would uphold the regulation under the deferential standards of *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984).

Due to the "operational realities" of health care payment systems, HCFA often does not know and cannot readily ascertain whether a given insurance company is acting as a conventional insurer or a third party administrator with respect to any given claim. To expedite its recovery of conditional Medicare payments, HCFA includes TPAs as entities

"required or responsible to pay" within the meaning of the MSP statute. HCFA's approach is consistent with both the statute's plain language and its underlying purpose. TPAs are literally "required" and "responsible" to pay claims filed under the primary health plans that they administer. Treating TPAs as entities "responsible to pay" facilitates governmental recovery of "conditional" Medicare payments, an underlying purpose of the MSP statute.

The majority rejects HCFA's statutory interpretation, explaining that a literal reading of the relevant statutory language proves too much. The majority points out that banks, on which group health plans draw their benefits checks, are also literally "required" and "responsible" to pay for medical services covered by the plans, yet it would be unreasonable to construe the relevant statutory language as extending to them. In my view, the majority glosses over salient differences between banks and third party administrators in the health care payment context that make it reasonable to regard TPAs, but not banks, as entities "required or responsible to pay" within the meaning of the MSP statute.

When a health plan draws a benefits check, it effectively orders its bank to pay a specified sum to a designated payee. It delegates no authority to the bank to make discretionary judgments concerning the payment or processing of subscribers' health care claims. TPAs, by contrast, frequently make such judgments on behalf of plans they administer. As sophisticated, repeat players in the health insurance field, TPAs, unlike banks, are often better situated than health plan providers to oversee primary plan compliance with MSP statutory requirements. HCFA cannot readily distinguish those TPAs that

exercise such oversight from those whose duties are purely clerical.

HCFA's Third Party Administrator Liability regulation is both consistent with the MSP statute's plain language and reasonably calculated to effectuate the statute's underlying purpose. Under Chevron this is sufficient. Notwithstanding the majority's indications to the contrary, determinations of reasonableness do not turn on whether a regulation is "necessary to accomplish Congress's goals." I would uphold the regulation.

B. *Retroactivity*

Although I concur in the majority's judgment regarding the retroactivity of HCFA's "double payment" regulation, 42 C.F.R. § 411.24(i), I write separately because I neither subscribe to the majority's exposition of *Sentara-Hampton General Hosp. v. Sullivan*, 980 F.2d 749 (D.C.Cir.1992) (per curiam) nor distinguish agency from Article III adjudications in analyzing the challenged regulations' retroactivity.

Retroactive rulemaking lies beyond the Secretary's power. *Bowen v. Georgetown University Hospital*, 488 U.S. 204, 109 S.Ct. 468, 102 L.Ed.2d 493 (1988). I agree with the majority that the gravamen of retroactivity is a rule's practical impact, not its "interpretive" or "legislative" label. A rule is retroactive if it "takes away or impairs vested rights acquired under existing law, or creates a new obligation, imposes a new duty, or attaches a new disability in respect to transactions or considerations already past." *Association of Accredited Cosmetology Schools v. Alexander*, 979 F.2d 859, 864 (D.C.Cir.1992) (internal citations omitted).

Applying this standard to the facts of this case, HCFA's "double payment" regulation, 42 C.F.R.

§ 411.24(i), is impermissibly retroactive with respect to transactions that occurred prior to November 13, 1993, the regulation's effective date. Prior to adopting its "double payment" regulation, HCFA did not interpret "responsible to pay" to include insurers and self-insured employers who had already paid for the item or service rendered. By construing those "responsible to pay" to include these entities, HCFA's "double payment" regulation marks a sea change in governmental policy. Because the regulation imposes new obligations, duties, and liabilities on these entities, I concur in the majority's judgment that 42 C.F.R. § 411.24(i) cannot apply to payments made before its effective date.

The majority reads *Sentara-Hampton General Hosp. v. Sullivan*, 980 F.2d 749 (D.C.Cir.1992) (*per curiam*) to suggest that our holding would be different if HCFA had applied 42 C.F.R. § 411.24(i) in an internal agency adjudication. I read *Sentara-Hampton* differently. The regulations at issue in that case merely clarified and reaffirmed the reimbursement standard to which HCFA already subjected regulated parties before the Hospital borrowed the funds for which it sought reimbursement. Unlike the regulations at issue in *Sentara-Hampton*, HCFA's double payment regulation does more than simply clarify an underlying statute or pre-existing policy; it effects a substantive change in the duties and liabilities of regulated parties.

HCFA's "third party administrator" regulation, 42 C.F.R. § 411.24(e), also effects a substantive change in the obligations, duties, and liabilities to which TPAs are subject. By the terms of their contracts, TPAs typically do not underwrite the health plans that they administer; they simply process claims filed under health plans for which another entity assumes

financial responsibility. Before HCFA promulgated § 411.24(e) in 1989, it had interpreted the statutory reference to those "responsible to pay" to include only entities that assumed financial responsibility for claims filed. By holding third party administrators liable for repayment of conditional Medicare payments, § 411.24(e) imposes new obligations, duties, and liabilities on TPAs. Consequently, the government could not validly apply 42 C.F.R. § 411.24(e) to claims and payments made prior to its effective date.

C. *Conclusion*

I concur both in the court's analysis of HCFA's "double payment," "Medigap extension," and "mandatory notice" regulations, 42 C.F.R. §§ 411.24(i), 411.32(a)(1), and 411.25(a), as consistent with the Medicare as Secondary Payer statute and its analysis of HCFA's "claims filing override" regulation, 42 C.F.R. § 411.24(f), as inconsistent with that statute. I too think that HCFA's "double payment" regulation is impermissibly retroactive but so conclude on a different basis than the majority. As to the court's holding that HCFA's "third party administrator" regulation, 42 C.F.R. § 411.24(e), is inconsistent with the Medicare as Secondary Payer statute, I dissent. If the applicability of that regulation were limited to claims or transactions that occurred after the regulation's effective date, I would find the regulation valid.

**APPENDIX B**

UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

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Civ. A. Nos. 90-1528 (RCL), 90-1356 (RCL)

BLUE CROSS AND BLUE SHIELD ASSOCIATION,
Plaintiff
v.

LOUIS W. SULLIVAN, ET AL., Defendants
HEALTH INSURANCE ASSOCIATION OF AMERICA, INC.,
Plaintiff

v.

LOUIS W. SULLIVAN, ET AL., DEFENDANTS

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April 7, 1992

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MEMORANDUM OPINION

LAMBERTH, District Judge.

This matter comes before the court upon the parties' cross-motions for summary judgment. Plaintiff in Civil Action No. 90-1528, Blue Cross and Blue Shield Association ("BCBS"), a not-for-profit organi-

zation, is the owner and licensor of Blue Cross and Blue Shield service marks. Among other things, BCBS provides support services for seventy-four autonomous not-for-profit health insurance companies or member plans which are located throughout the United States.[1] Member plans issue health insurance policies to individuals as well as groups. BCBS asserts that various regulations that were promulgated under the Medicare statute are arbitrary and capricious, an abuse of discretion or are otherwise not in accordance with law in violation of the Administrative Procedure Act, 5 U.S.C. § 706(2) (1988) ("APA").

Plaintiff in Civil Action No. 90-1356, Health Insurance Association of America, Inc. ("HIAA"), represents approximately three-hundred and twenty commercial health insurance companies that enter into various types of contractual agreements with employers and other entities which sponsor employer group health plans ("EGHP's"). HIAA challenges many of the same regulations as BCBS. Accordingly, on September 21, 1990, the court granted defendants' oral motion to consolidate HIAA's case with Civil Action No. 90-1528. Defendants in these cases are Dr. Louis Sullivan, the Secretary of the United States Department of Health and Human Services ("HHS"), and Gail R. Wilensky, the Administrator of the Health Care Financing Administration ("HFCA").

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[1] BCBS's Board of Directors has authorized this litigation on behalf of all of its member plans with the exception of Blue Cross and Blue Shield of Michigan and Associated Insurance Companies, Inc., doing business as Blue Cross and Blue Shield of Indiana.

Also involved in these cases are amici Casmira Gayton, Jeanette and Clarence Howlett, who support plaintiffs' motions for summary judgment on the ground that 42 C.F.R. § 411.24(i) is arbitrary and capricious.

## I. FACTS

Medicare, which is authorized by Title XVIII of the Social Security Act, is an extensive federally funded program that provides health insurance for the aged and the disabled. 42 U.S.C. § 1395 *et seq.* (1988). Medicare is divided into two parts: Part A, which provides insurance for inpatient institutional services, home-health services and other post-hospital services, *id.* at §§ 1395c through 1395i-3, and Part B, which covers physician, outpatient hospital and various other health services. *Id.* at §§ 1395j through 1395w-2. Both Part A and Part B contain deductible and coinsurance provisions. See *id.* at ss 1395e and 1395b-1. As a result, Medicare does not pay the entire cost of health care that is provided to beneficiaries.

The Medicare program is administered by HCFA. HCFA is responsible for developing policies and regulations to ensure compliance with the Medicare statute. HCFA does not, however, process and pay Medicare claims, but rather contracts with private insurance companies to do so. *See id.* at §§ 1395h, 1395u.

From its inception until 1980, Medicare was the primary source of payment for the medical expenses for nearly all of its beneficiaries.[2] Accordingly, under

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[2] The only exception to this general rule occurred where payments had been, or reasonably could have been, made by a

most circumstances Medicare was the "primary" payer of health care benefits and EGHP's[3] were "secondary" payers, liable only for the costs that remained after Medicare made its payments. Accordingly, most insurance companies' contracts with employers and EGHP's only covered "secondary" costs.

In 1981, Congress enacted the Medicare Secondary Payer Statute ("MSP statute") in an effort to reduce federal spending and to protect the financial well being of the Medicare program.[4] See 42 U.S.C. § 1395y (1988). The MSP statutory scheme applies to Medicare beneficiaries who have alternative sources of payment for health care services, such as insurance or an EGHP, and requires those alternate sources to pay health care costs "primary" to Medicare. The intent of this statute was to cut the costs of the Medicare program by requiring that Medicare pay "secondary" to alternate sources.[5]

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workers compensation law or plan. *See* 42 U.S.C. §§ 1395y(b)(1) (1988).

[3] An EGHP is defined as "any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of such employees or former employees." 42 U.S.C. § 1395y(b)(1)(A)(v) (1990) (citing to 26 U.S.C. § 5000(b)(1) (Supp.1991).

[4] *See* 128 Cong. Rec. 22402 (1982) (Senator Dole referring to the Tax Equity and Fiscal Responsibility Act of 1982).

[5] The MSP statute has been amended numerous times since 1981, and each amendment has expanded the scope of the MSP scheme. *See* The Omnibus Reconciliation Act of 1980 ("ORS '80"), Pub.L. No. 96-499 (which amended 42 U.S.C. § 1395y to make Medicare payments secondary to automobile, liability and no-fault insurance); The Omnibus Budget Reconciliation Act of 1981 ("OBRA '81"), Pub.L. No. 97-35; The Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), Pub.L. No. 97-

Three provisions of the MSP statute are relevant to this case. The first expressly mandates that Medicare pay secondary to alternate sources. It states that a Medicare payment "may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—(1) payment has been made, or can reasonably be expected to be made, with respect to the item or service" that is provided by an EGHP to cover one or more of the three categories of MSP beneficiaries.[6] 42 U.S.C. § 1395y(b)(2)(A)(i) (Supp.1990) (emphasis added).

The second relevant provision applies when Medicare mistakenly makes the primary payment. This provision allows the government to recover any payments that should have been made by the alternate source. This section, entitled "Conditional Payment," states that: [a]ny payment under this subchapter with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund Established by this subchapter when notice or other information is received that payment for such item has been or could be made under such subparagraph. *Id.* at § 1395y(b)(2)(B).

The third salient provision provides the mechanism by which the government can recover conditional

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248; The Deficit Reduction Act of 1984 ("DEFRA"), Pub.L. No. 98-3691; The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Pub.L. No. 99-272; The Omnibus Budget Reconciliation Act of 1986 ("OBRA '86"), Pub.L. No. 99-509; and The Omnibus Budget Reconciliation Act of 1989 ("OBRA '89").

[6] The three categories are the working aged, disabled active individuals in large group health plans and individuals with end stage renal diseases. See 42 U.S.C. § 1395y(b)(1)(A), (B), (C).

Medicare payments. This section provides that: [i]n order to recover payment under this subchapter for such an item or service, the United States may bring an action against any entity which is required or responsible under this subsection to pay with respect to such item or service (or any portion thereof) under a primary plan . . . or against any entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service. *Id.* at § 1395y(b)(2)(B)(ii). Thus, upon making a conditional payment, the government may "bring an action against any entity which is required or responsible to pay" to recover its expenditure. *Id.*

From 1983 until 1989, the regulations that were promulgated by HCFA to enforce the MSP statute were rather consistent in their scope and effect. These rules and regulation stated that upon making a conditional payment the government may bring an action against the employer or EGHP.[7] These rules and regulations also required the beneficiary to cooperate in any action brought by HCFA against the employer or the plan.[8]

In 1989, HCFA promulgated new regulations to implement the MSP statute, five of which are at issue in these cases. See 54 Fed.Reg. 41,716-41,747 (Oct. 11, 1989) (later codified at 42 C.F.R. §§ 405, 411, 412 and 489). The 1989 regulations reflected the government's concern that the MSP statute had fallen far short of the government's expectations in terms of reducing the cost of the Medicare program. *See* GAO

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[7] *See e.g.*, 48 Fed.Reg. 15,905-06 (Apr. 13, 1983) (later codified at 42 C.F.R. § 405.344(a) (1989).

[8] See footnote 7, *supra*.

Report of November 29, 1988, tab 3 to defendants' motion for summary judgment. Government studies estimated that the federal government suffered losses between $400 million and $1 billion per year prior to 1989 due to the Medicare program. *See* Investigation by the Office of the Inspector General ("OIG"), tab 1 to defendants' motion for summary judgment.

The OIG's study attributed this massive financial loss to a variety of factors, including the fact that "Medicare contractors do not aggressively pursue MSP claims and there are few incentives for Medicare contractors to pay claims," as well as the fact that "[s]ome insurance companies have avoided compliance with MSP requirements and continued their previous practice of paying benefits secondary to Medicare, long after the effective date of the MSP statutes." *Id.* at 2. The report concluded that "the most direct solution may be to require either insurance companies or employers, depending on which maintains the beneficiary files, to report to the government those employees who have health coverage who fall into MSP categories." *Id.* at 3. Consequently, the 1989 regulations at issue here expanded HCFA's ability to recover conditional payments by permitting HCFA to bring direct actions against third party payers, *i.e.* insurance companies, as well as employers and EGHP's.

## II. ANALYSIS

### A. Standard of Review

The language of Rule 56(c) of the Federal Rules of Civil Procedure indicates that summary judgment is appropriate when examination of the record as a whole reveals "no genuine issue as to any material

fact and that the moving party is entitled to judgment as a matter of law." In examining the record, the court must view all inferences in the light most favorable to the nonmoving party. *Matsushita Elec. Industrial Co.* v. *Zenith Radio Corp.*, 475 U.S. 574, 587, 106 S.Ct. 1348, 1356, 89 L.Ed.2d 538 (1986).

The scope of a court's review of an agency's exercise of its rulemaking authority is limited. *United Mineworkers of America, International Union* v. *Dole*, 870 F.2d 662, 666 (D.C.Cir.1989). Pursuant to Chevron, the court must first consider whether Congress manifested an "unambiguously expressed intent" that resolves the dispute of the statute's meaning. *Abbott Laboratories* v. *Young*, 920 F.2d 984, 987 (D.C.Cir.1990), *cert. denied sub nom. Abbott Laboratories* v. *Kessler*, — U.S. ——, 112 S.Ct. 76, 116 L.Ed.2d 49 (1991) ("*Abbott Labs*") (quoting *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43, 104 S.Ct. 2778, 2781, 81 L.Ed.2d 694 (1984)). The language of the statute in question is the best indication of congressional intent. *Abbott Labs*, 920 F.2d at 987. If the statute clearly speaks to the issue, then the reviewing court need not defer to the agency's interpretation because the court is in as good a position as the agency to interpret and apply the statute. The court may also look to the statute's legislative history to determine whether Congress clearly addressed the issue. *See id.* at 988.

On the other hand, if the language of the statute does not clearly address the issue at hand, the court must then proceed to the second step of Chevron and ask whether the agency's construction "falls within the bounds of reasonableness." *Id.* The court in Abbott Labs stated that "[t]he 'reasonableness' of an agency's construction depends on the construction's

'fit' with the statutory language as well as its conformity to statutory purposes." *Id.* It is in this context that agencies are to use their discretion when interpreting the statute and that the reviewing court is to defer to their expertise and judgment.

When reviewing an agency's action under the second step of Chevron, the APA applies. Pursuant to the APA, a court reviewing agency action will hold unlawful and set aside agency action, findings and conclusions that are found to be arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law. *See* 5 U.S.C. § 706(2)(A) (1982). In general, this standard of review is highly deferential and presumes agency action to be valid. *See Environmental Defense Fund, Inc.* v. *Costle*, 657 F.2d 275, 283 (D.C.Cir.1981) (citing *Citizens to Preserve Overton Park, Inc.* v. *Volpe*, 401 U.S. 402, 416, 91 S.Ct. 814, 823, 28 L.Ed.2d 136 (1971)). The court must affirm the agency's decision if a rational basis for that decision exists, even if the court disagrees. *Costle*, 657 F.2d at 283. While deferential to agency action, the court's review of the facts must be searching and careful; the agency's action must be based on a consideration of relevant factors. *Id.* The scope of the court's review of agency action is usually confined to the full administrative record before the agency at the time the agency action was taken. *Volpe*, 401 U.S. at 420, 91 S.Ct. at 825.

B. Regulations at Issue

Plaintiffs assert that five of the 1989 regulations are arbitrary and capricious in violation of the APA. Due to the number of regulations at issue in these cases, the court shall address each regulation individually.

1. 42 C.F.R. § 411.24(e)

Both plaintiffs challenge 42 C.F.R. § 411.24(e) which states: Recovery from third parties. HCFA has a direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan, or program, and a third party administrator. A third party administrator ("TPA") agreement, also known as an administrative services only agreement, is an arrangement by which the insurance company assumes no risk to provide coverage or pay for health care benefits, but rather agrees only to administer the payment of health care benefits that are self-funded by the employer. TPA's may be the parties which physically make the payments for health care benefits, but they do so using the employer's money.

Plaintiffs assert that this section violates the APA because it exceeds HCFA's statutory authority. Plaintiffs do not dispute the fact that when they agree to insure payments provided for by employers or EGHP's they become entities "responsible to pay" under the MSP statute and as such HCFA may bring a direct action against them for the benefits. Plaintiffs assert, however, that the MSP statute clearly does not permit HCFA to bring a direct action against insurance companies when they are acting as TPA's. Plaintiffs claim that this regulation improperly changes the wording of the statute by adding the word "making" to the "party responsible to pay" language. Plaintiffs allege that when the statute refers to the "party responsible to pay" it means the party out of whose pocket the money is coming, and that this clearly does not pertain to TPA's just because they issue the check.

Defendants, on the other hand, claim that this regulation is "entirely consistent" with the language of the MSP statute. Defendants state that the use of TPA's has vastly expanded in recent years and that while the roles of TPA's vary, they are generally responsible for processing claims and making payments under employer plans. Consequently, defendants claim that HCFA reasonably concluded that they are entities responsible to pay under the MSP statute. Defendants further assert that if Congress had intended the MSP statute to apply only to those parties ultimately required to pay for a service, then it would have so provided in the language of the statute. Defendants contend that Congress left the language as it is to allow a right of recovery that goes beyond the parties that are ultimately required to pay.

The court shall grant summary judgment for defendants and uphold Section 411.24(e). The MSP statute grants HCFA a right of action against the party required or responsible to pay. Congress does not specify whether this provision grants a right of action against the party who in fact makes the payment or the party whose money is being used to make the payment. The former interpretation would include TPA's within the scope of the statute while the latter interpretation would not. Since the statute does not clearly speak to this issue, the court shall proceed to step two of the Chevron analysis.

Under step two, the court cannot find that section 411.24(e) is an unreasonable interpretation of the MSP statute in violation of the APA. The MSP statute was intended to save the government money in the administration of the Medicare program. It is reasonable for HCFA to interpret, based on the unclear language of the statute, that the party

required or responsible for making payment includes TPA's. This interpretation assures that the government will be able to recover conditional payments and thereby serves the intent and purpose of the MSP statute. The result of this regulation is that TPA's are left to work out with the employer or EGHP which party must actually put forth the money. The court cannot find that this result is arbitrary or capricious, or otherwise in violation of the APA.[9]

2. 42 C.F.R. § 411.24(f)

Plaintiffs also challenge 42 C.F.R. § 411.24(f), which provides: Claims filing requirements. (1) HCFA may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services. (2) However, HCFA will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is primary to Medicare for those particular service. . . .

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[9] The court recognizes that two other courts have addressed this matter and have arrived at a contrary result. *See Provident Life and Accident Insurance Co.* v. *United States*, 740 F.Supp. 492, 503 (E.D.Tenn.1990) and *United States* v. *Blue Cross and Blue Shield of Michigan*, 726 F.Supp. 1517, 1521 (E.D.Mich.1989). The court does not, however, find their holdings on this issue persuasive or controlling.

Plaintiffs claim that this section violates the APA because it exceeds the authority granted by the MSP statute by allowing HCFA to recover from entities that are not required or responsible to pay. Plaintiffs assert that their responsibility to pay claims under the statute is contingent upon the employer or EGHP complying with the terms and conditions of their contracts, such as claims filing requirements. Plaintiffs allege that if these conditions precedent are not met they are not required or responsible to pay.

Defendants, in contrast, assert that this regulation applies only when a beneficiary or provider presents a claim in the first instance to Medicare when Medicare is not in fact the primary payer. Under these circumstances, when HCFA subsequently determines that Medicare should be the secondary payer, defendants assert that HCFA may override the plan's procedural rules to ensure that the government may recover from the entity responsible to pay. Defendants also point out that if HCFA cannot override these procedural requirements, then insurance companies could adopt unreasonably short filing requirements to avoid their responsibility to pay.

The court rejects plaintiffs' arguments and shall grant summary judgment for defendants regarding this regulation. Under Chevron step one, Congress specifically addressed this matter when it affirmatively required Medicare to be the secondary payer and when it stated that Medicare payments are conditioned upon reimbursement "when notice or other information is received that payment for such item has been or could have been made." 42 U.S.C. § 1395y(b)(2)(B).

Further, even if the court were to find that Congress did not speak to this issue, the court cannot find that HCFA's determination—that this provision is necessary to give effect to the MSP statute—is arbitrary or capricious or otherwise in violation of the APA under step two of Chevron. The overriding purpose of the statute is to assure that Medicare is the secondary payer. In order to effectuate this purpose, Medicare must have the ability to go after those entities who are responsible for making primary payments. This ability cannot be limited by the entities' private contractual provisions. *See United States* v. *Kimbell Foods, Inc.*, 440 U.S. 715, 726, 99 S.Ct. 1448, 1457, 59 L.Ed.2d 711 (in which the Court held that federal law governs questions involving the government's rights under nationwide federal programs). *See also United States* v. *Pisani*, 646 F.2d 83, 86 (3d Cir.1981) (in which the court applied this principle in the Medicare context, stating that "[t]he federal statute which sets guidelines for the Medicare program is the source of the Government's right to recover overpayments. Thus federal law governs").

Moreover, plaintiffs' arguments are based on an interpretation of the MSP statute which would limit the government's right of recovery solely to subrogation. While the statute does provide that the government shall be subrogated to any right of an individual to a payment under the plan, *see* 42 U.S.C. § 1395y(b)(2)(B), the statute also grants the government a direct right of action to recover conditional payments from entities that are required to make primary payments. *Id.* at § 1395y(b)(2)(B)(ii).

In its opposition to defendants' motion for summary judgment, BCBS asserts that Section 411.24(f) is invalid because it violates ERISA to the extent that

it requires an insurer or TPA to make payments at variance with the claims procedures of an EGHP. The court rejects this claim. As defendants properly point out, Congress expressly established that it did not intend ERISA to supplant other federal statutes. *See* 29 U.S.C. § 1144(d) (1985). In addition, the Department of Labor, the agency responsible for the administration of ERISA, has specifically advised HCFA that "[a]s a Federal law, the Medicare law, including amendments thereto and related rules and regulations, would not, by virtue of ERISA section 514(d), be preempted by the provision of title I of ERISA." *See* Defendants' motion for summary judgment, tab 10. Further, Section 411.24(f) does not conflict with the purpose of ERISA, which is to assure that plans be administered according to their written terms to protect plan beneficiaries and participants.

3. 42 C.F.R. § 411.24(i)

Plaintiffs also assert that 42 C.F.R. § 411.24(i) violates the APA. This regulation states: Special Rules. (1) In the case of liability insurance settlements and disputed claims under employer group health plans and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party. (2) The provisions of paragraph (i)(1) of this section also apply if a third party payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional payment. Subsection (h) states that "[i]f the beneficiary or other party receives a third party

payment, the beneficiary or other party must reimburse Medicare within 60 days."

This regulation permits HCFA to seek recovery of a conditional payment from a third party payer which has reimbursed the beneficiary when it knew or should have known that Medicare had made a conditional payment in the event that HCFA cannot recover from the beneficiary. Plaintiffs assert that this regulation goes far beyond the MSP statute because, under these circumstances, the insurance companies have fulfilled their obligation and are no longer the party responsible. The upshot of this regulation, according to plaintiffs, is that it allows HCFA to subject insurance companies to double liability.

The amici assert that this regulation imposes undue hardship on insureds because it coerces insurance companies to pay money that would otherwise go to insureds directly to Medicare in order to avoid double liability. The amici conclude that this regulation violates the protections provided for beneficiaries by the Medicare statute.

Defendants counter by stressing that this regulation applies only in those circumstances in which the third party has issued payment with knowledge that Medicare had already made a conditional payment, and that plaintiffs can avoid double liability by reimbursing Medicare for the conditional payment rather than making a double payment to the beneficiary. Defendants assert that it is fair for HCFA, as a last resort, to seek recovery from insurance companies under these limited circumstances. Further, defendants point out that this section only applies in cases in which the statutory order of payment has not been followed, and that plaintiffs seek to compound this error by

permitting insurance companies to disregard the government's statutory right to recover conditional payments and knowingly make incorrect payments to the beneficiary.

The court shall grant summary judgment for defendants and uphold this regulation. This regulation is reasonably necessary to carry out the MSP statute's requirement that Medicare be the secondary payer. The court cannot find that it is arbitrary or capricious or beyond HCFA's statutory authority for HCFA to determine, based upon the government's right to recover from entities that are statutorily required to pay primary for health care benefits, that the government may require primary paying entities to reimburse the government for payments that they know or should have known that were improperly paid.

4. 42 C.F.R. § 411.25

HIAA challenges 42 C.F.R. § 411.25. This regulation, entitled "Third party payer's notice of mistaken Medicare primary payments," provides that: (a) If a third party payer learns that HCFA has made a Medicare primary payment for services for which the third party payer has made or should have made primary payment, it must give notice to that effect to the Medicare intermediary or carrier that paid the claim. (b) The notice must describe the specific saturation and the circumstances (including the particular type of insurance coverage as specified in § 411.20(a)) and, if appropriate, the time period during which the insurer is primary to Medicare. (c) If a plan is self-insured and self-administered, the employer must give the notice to HCFA. Otherwise, the

insurer, underwriter, or third party administrator must give the notice.

HIAA claims that this regulation is invalid because it imposes on insurance companies the obligation to cure HCFA's errors and that such an imposition is not authorized by the statute. HIAA also asserts that this new obligation imposes new administrative costs on insurance companies, and that none of the regulations that existed prior to 1989 imposed such a notice requirement upon insurance companies. HIAA further claims that Congress intended to require HCFA and its contractors to assume full responsibility for the administration of the MSP statute, not private insurance companies. HIAA then alleges that this notice provision was promulgated in violation of the APA because HCFA did not provide interested parties with adequate notice of this provision.

Defendants state that this regulation imposes only a minor obligation on entities whose cooperation Congress has deemed essential to the MSP scheme. Defendants assert that it is a reasonable means of ensuring that Medicare payments are made in the proper sequence and that it is necessary to enable the government to recover conditional payments from the party primarily responsible to pay.

The court cannot find that this regulation is arbitrary or capricious, or otherwise in violation of the APA. Section 411.25 merely provides that third party payers must notify Medicare when they learn of improper payments. This regulation provides a mechanism for ensuring that Medicare pays secondary and thereby directly serves the policy and purpose of the MSP statute. As defendants properly point out, the MSP statutory scheme "is not a game of hide and seek, in which private parties may sit back and wait until the government independently deter-

mines that private coverage exists." Rather, the MSP scheme depends heavily upon the exchange of information by all effected parties to assure that payments are made in the proper sequence. Further, an agency's change of course with respect to a particular policy does not, by itself, suggest a lack of reasoned decisionmaking. *See National Resources Defense Counsel* v. *United States Environmental Protection Agency*, 822 F.2d 104, 112 (D.C.Cir.1987).

Regarding HIAA's lack of adequate notice contention, HCFA's notice was adequate under the APA. HCFA adopted this regulation in response to comments by interested parties, including insurance companies, that they were hindered by the lack of guidance by HCFA as to the manner in which the government and private parties should coordinate MSP payments. *See* 54 Fed.Reg. 41,718 (Oct. 11, 1989). An agency's notice of proposed rulemakings must be sufficient to apprise interested parties of the issues involved, but that it need not specify every precise proposal which the agency may adopt as a rule. *See Id. See also National Resources Defense Counsel* v. *United States Environmental Protection Agency*, 824 F.2d 1258, 1283 (1st Cir.1987). The notice the interested parties received in this case was adequate to put them on notice of the issues involved.

5. 42 C.F.R. § 32(a)

BCBS challenges 42 C.F.R. § 32(a), entitled "Basis for Medicare Secondary Payments," which states: Basic Rules. (1) Medicare benefits are secondary to benefits payable by a third party payer even if State law or the third party payer states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries.

(2) Except as provided in paragraph (b) of this section, Medicare makes secondary payments, within the limits specified in paragraph (c) of this section and in § 411.33, to supplement the third party payment if that payment is less than the charges for the services and, in the case of services paid on other than a reasonable charge basis, less than the gross amount payable by Medicare under § 411.33(e). Paragraph (b) provides that Medicare does not make a secondary payment if the provider or supplier accepts as full payment, a third party payment that is less than its charges.

BCBS states that this regulation is an attempt by HCFA to convert insurance contracts that may provide only limited health care benefits into a comprehensive health care program. In doing so, BCBS asserts that this rule goes far beyond the reach of the MSP statute. BCBS points out that the statute itself contains many mechanisms to ensure that insurance companies comply with the statute, and that this provision was not intended or envisioned by Congress. These provisions include a punitive excise tax against an employer whose EGHP does not conform with the MSP statute,[10] a section which subjects EGHPs to lawsuits by a private parties if they fail to pay primary,[11] a section which subjects EGHPs to lawsuits by the government if they fail to pay primary,[12] and a section which allows the government to sue for Medicare overpayments from the party that received the payment or the third party who should have made the payment.[13]

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[10] 42 U.S.C. § 1395y(b)(3)(B); 26 U.S.C. § 5000.

[11] 42 U.S.C. § 1395y(b)(3)(A).

[12] 42 U.S.C. § 1395y(b)(2)(B)(ii).

[13] 42 U.S.C. § 1395y(b)(2)(B)(ii).

The court shall grant defendants' motion for summary judgment on this issue and uphold Section 411.32(a). As is stated *supra*, the only limit on the government's ability to recover conditional payments is set forth by the MSP statute. This statute requires that Medicare pay secondary and grants the government a direct right of action to recover improper primary payments. This is regulation is reasonable. It gives effect to the government's right of action by ensuring that third parties do not avoid their obligation to make primary payments by relying on contractual terms or state law provisions which permit secondary payments.

6. Retroactivity

HIAA, relying exclusively on *Bowen* v. *Georgetown University Hospital*, 488 U.S. 204, 109 S.Ct. 468, 102 L.Ed.2d 493 (1988), asserts that if these regulations are permissible then they should be given prospective effect only. HIAA points out that the Supreme Court in *Bowen* held that rules with retroactive effect can be upheld only if Congress expressly granted the power to enact rules that apply retroactively and that the Medicare statute did not grant the power to enact retroactive rules.

HIAA fails to demonstrate, however, that the regulations at issue in this case are retroactive. First, *Bowen* is distinguishable. In *Bowen*, the Supreme Court dealt with the Secretary of HHS's revision of the wage index for Medicare's cost limit schedules. *Id.* at 206, 109 S.Ct. at 470. Prior to 1981, the wage index for a given geographic area was based upon the average salary level in all hospitals in the area. *Id.* In 1981, the Secretary promulgated a new cost-limit rule which provided that wages paid by

Federal Government hospitals would be excluded from that calculation. *Id.*

After the adoption of the 1981 rule, Congress amended the Medicare Act to require a different cost reimbursement program. *Id.* at 207, 109 S.Ct. at 471. In 1983, a United States District Court struck down the 1981 regulation on the ground that it violated the APA because it was promulgated without adequate notice and comment. *Id.* at 206, 109 S.Ct. at 470. In 1984, the Secretary reissued the 1981 rule to apply exclusively to a fifteen month period beginning 1981. *Id.* at 207, 109 S.Ct. at 471. Seven hospitals challenged this rule on the ground that its retroactive provision violated both the APA and the Medicare Act. *Id.*

The Supreme Court noted that retroactivity is not favored by the law and that an agency's rulemaking authority cannot be applied retroactively "unless that power is conveyed by Congress in express terms." *Id.* at 208, 109 S.Ct. at 471. The Court stated that "[e]ven where some substantial justification for retroactive rulemaking is presented, courts should be reluctant to find such authority absent an express statutory grant." *Id.* at 208-09, 109 S.Ct. at 471. The Court then concluded that the Medicare Act does not give the Secretary the authority to promulgate retroactive cost-limit rules and struck down the regulation. *Id.* at 215, 109 S.Ct. at 475.

The present case is clearly distinguishable from *Bowen*, and thus *Bowen* is not controlling. The regulations in question in this case do not, like the rule in *Bowen*, apply to a discrete period of time in the past. Rather, as is discussed *supra*, these regulations reflect HCFA's current reasonable interpretation of the MSP statute and are designed to give present effect to the statute.

The court finds that *Chemical Waste Management, Inc.* v. *United States Environmental Protection Agency*, 869 F.2d 1526 (D.C.Cir.1989), is instructive on this issue of whether these regulations are retroactive. *Chemical Waste* involved the Resource Conservation and Recovery Act ("RCRA") of 1976, which, among other things, adopted two definitions of hazardous waste: (1) specific listed hazardous wastes; and (2) any solid waste which demonstrates one of four characteristics.[14] *Id.* at 1529. The RCRA regulated the way in which hazardous waste could be disposed of. *Id.*

Prior to 1988, EPA regulations had established that leachate[15] derived from hazardous waste is itself a hazardous waste. *Id.* at 1530. In 1988, the EPA promulgated a new rule which stated that leachate derived from multiple hazardous wastes would be deemed to contain each of the wastes from which it was generated and must therefore be treated according to the standards applicable to each of the underlying wastes. *Id.* at 1530. Further, under the 1988 rule, leachate which is managed after the underlying wastes have been listed as hazardous waste will be deemed hazardous and must be treated accordingly. *Id.* at 1531. Thus, the fact that the underlying waste was not considered hazardous at the time it was disposed of was irrelevant in determining the treatment required for leachate. *Id.* Petitioners challenged the 1988 rule on the ground that the application of this rule to leachate derived

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[14] These four characteristics are ignitability, corrosivity, reactivity and extraction procedure toxicity. See *Chemical Waste*, 869 F.2d at 1529.

[15] Leachate is produced when fluids such as rainwater pass through or by wastes stored in a landfill and collect components of the waste. See *Chemical Waste*, 869 F.2d at 1530.

from wastes which were not considered hazardous at the time that they were disposed constituted retroactive rulemaking. *Id.*

The Court of Appeals for the District of Columbia Circuit held that this rule was not retroactive. *Id.* at 1536. The court noted that the rule did not impose any legal penalty on the disposal of waste which was not considered hazardous at the time of its disposal and did not require clean-up of such wastes. *Id.* The court recognized that landfill operators were required to collect and manage leachate and that this rule constrained their present range of options even though they could not have foreseen such consequences at the time that the waste was disposed of. *Id.* The court held, however, that the rule was prospective because treatment or disposal of leachate will be subject to the rule only if that treatment or disposal occurred after the promulgation of the rule. *Id.* The court stated that: [i]t is often the case that a business will undertake a certain course of action based on current law, and will then find its expectations frustrated when the law changes. This has never been thought to constitute retroactive rulemaking, and indeed most economic regulation would be unworkable if all laws disrupting prior expectations were deemed suspect. *Id.*

Similarly, the regulations at issue in the present case are not retroactive for the same reasons as the District of Columbia Circuit cited in *Chemical Waste*. These regulations do not impose any legal penalty on plaintiffs for entering in TPA agreements at a time when it may not have been HCFA's policy to bring direct actions against TPA's for conditional payments. Just because these regulations constrain plaintiffs' present conduct based upon actions which were taken at a time when the consequences of such

actions may have been unforseen does not mean that these regulations are retroactive. Moreover, HCFA may only apply these regulations in direct actions against third party payers that occur after the promulgation of these regulations. The fact that HIAA's expectations were frustrated by the 1989 regulations does not dictate these regulations are retroactive.

Although HIAA's retroactivity claim was based entirely on *Bowen*, HIAA could not reasonably contend that the 1989 regulations at issue here impair rights that were vested by prior regulations. First, plaintiffs acknowledge that three of the five regulations in question, 42 C.F.R. §§ 411.24(f)(1), 411.24(i)(1) and (2), and 411.25(a) and (c), did not replace prior comparable regulations. Consequently, HIAA cannot assert that these 1989 regulations retroactively impaired rights that were vested by prior rules.

Second, the regulation which preceded the liability of third party payers provision, 42 C.F.R. § 411.24(e), stated that HCFA may bring an action against the employer or plan as appropriate.[16] This prior rule was silent as to whether HCFA could bring a direct action against TPA's. It did not prohibit direct actions against TPA's; rather it merely permitted direct actions against employers or EGHP's. In addition, as is noted *supra*, under Chevron step two, Section 411.24(e) is a reasonable interpretation of the MSP statute. Thus, HCFA always had the authority to bring direct actions against TPA's and this regulation does not impair any rights which were vested by any statute or prior regulations.

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[16] See footnote 7 *supra*.

As to 42 C.F.R. § 411.32(a)(1), there was no comparable preceding provision for the working aged, and the comparable preceding provision for end stage renal disease patients stated that Medicare benefits are secondary to employer policies or plans "even though the employer policy or plan states that its benefits are secondary to Medicare or otherwise excludes or limits its payments to Medicare beneficiaries." 42 C.F.R. § 405.327(a)(4). Section 411.32(a)(1) states that Medicare benefits are secondary to benefits payable by third parties even if state law or the third party payer states that its benefits are secondary to Medicare or otherwise limits its payments to Medicare beneficiaries.

Like Section 411.24(e), this regulation does not apply retroactively to impair rights that were vested by prior regulations. To begin with, no prior regulation even covered the working aged regarding this issue. As to those beneficiaries with end stage renal diseases, the prior regulation did not prohibit HCFA from seeking recovery from TPA's that try to limit their coverage to being secondary to Medicare, and, as is noted supra, this regulation is a reasonable interpretation of the MSP statute. Consequently, this regulation does not impair any rights that were vested by the prior regulation because HCFA always had the authority to allow such actions against third party payers.

7. Takings Clause

In its opposition to defendants' motion for summary judgment, BCBS alleges that some of the 1989 regulations amount to an uncompensated taking under the takings clause in violation of the fifth amendment because they impose duties on BCBS

plans which are in excess of the terms of their contracts. Summary judgment shall be granted for defendants on this issue. Not all regulatory schemes which alter contractual rights amount to a taking in violation of the Fifth Amendment to the Constitution. *See Connolly* v. *Pension Benefit Guaranty Corp.*, 475 U.S. 211, 223-25, 106 S.Ct. 1018, 1025-26, 89 L.Ed.2d 166 (1986). Regulations that "adjust[ ] the benefits and burdens of economic life to promote the common good" are an acceptable form of government action. *See Id.* at 225, 106 S.Ct. at 1026.

The Supreme Court has identified three factors which have "particular significance" when determining whether a government action constitutes a taking: (1) the economic impact of the regulation on the claimant; (2) the extent to which the regulation has interfered with distinct investment-backed expectations; an (3) the character of the government action. *Id.* at 225, 106 S.Ct. at 1026 (citing *Penn Central Transportation Co.* v. *New York City*, 438 U.S. 104, 98 S.Ct. 2646, 57 L.Ed.2d 631 (1978)).

Upon considering these factors, the court finds that the regulations at issue in this case do not constitute a compensable taking under the Fifth Amendment. In the present matter, as was the case in *Connolly*, the government is not "physically invad[ing] or permanently appropriat[ing] any of [plaintiffs'] assets for its own use." *Id.* at 225, 106 S.Ct. at 1026. Rather, the government is merely adopting procedures to assure that the parties which are responsible to pay primary fulfill their statutory obligation to do so and to allow the government to recoup conditional payments when these parties fail to fulfill their statutory obligation. These regulations also assure the protection of the Medicare trust funds.

Further, these regulations do not impose economic injury on plaintiffs. TPA's which are required to pay HCFA under these regulations are simply fulfilling their contractual duty as the parties responsible to pay Medicare costs as well as their statutory obligation to pay primary. TPA's may avoid such liability by amending their contracts with employer plans. Insurers have no vested rights in maintaining the status quo, especially given that the Medicare program is one of the most heavily regulated government programs in existence. See *Colonial Penn Insurance Co.* v. *Heckler*, 721 F.2d 431, 441 (3d Cir. 1983).

Finally, the United States Supreme Court has noted that uncompensated takings are prohibited " 'to bar Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole.' "*Connolly*, 475 U.S. at 227, 106 S.Ct. at 1027, (quoting *Armstrong* v. *United States*, 364 U.S. 40, 49, 80 S.Ct. 1563, 1569, 4 L.Ed.2d 1554 (1960)). As the government properly points out, fairness and justice would not be served by requiring taxpayers to bear the burden of paying for services that are covered by private health care plans.

A separate order shall issue this date.

ORDER AND JUDGMENT

This matter comes before the court upon the parties' cross-motions for summary judgment. Upon consideration of plaintiffs' motions, defendants' motion, the oppositions and replies thereto, the oral argument of counsel and the record herein, and for the reasons stated in the court's memorandum opinion of this date, it is hereby ORDERED that

1. Plaintiffs' motions for summary judgment are DENIED.

2. Defendants' motion for summary judgment is GRANTED.

3. Summary judgment is hereby entered on behalf of defendants.

4. These cases stand DISMISSED WITH PREJUDICE.

SO ORDERED.

APPENDIX C

# UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 92-5196
USDC CV 90-1356

HEALTH INSURANCE ASSOCIATION OF AMERICA, INC.,
APPELLANT

*v.*

DONNA E. SHALALA, SECRETARY OF
HEALTH AND HUMAN SERVICES, ET AL.
APPELLEES

and Consolidated Case No. 92-5197

[Filed July 21, 1994]

## ORDER

BEFORE: MIKVA, CHIEF JUDGE, WILLIAMS and HENDERSON, CIRCUIT JUDGES.

Upon consideration of appellees' petition for rehearing, filed June 27, 1994, it is

Ordered, by the Court, that the petition is denied.

Per Curiam
FOR THE COURT:
RON GARVIN, CLERK

BY:
Robert A. Bonner
Deputy Clerk

APPENDIX D

# UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 92-5196
USDC CV 90-1356

HEALTH INSURANCE ASSOCIATION OF AMERICA, INC.,
APPELLANT

*v.*

DONNA E. SHALALA, SECRETARY OF
HEALTH AND HUMAN SERVICES, ET AL.
APPELLEES

and Consolidated Case No. 92-5197

[Filed July 21, 1994]

## ORDER

BEFORE: MIKVA, CHIEF JUDGE; WALD, EDWARDS, SILBERMAN, BUCKLEY, WILLIAMS, GINSBURG, SENTELLE, HENDERSON, RANDOLPH and ROGERS, CIRCUIT JUDGES.

Appellees' Suggestion For Rehearing In Banc has been circulated to the full Court. No member of the Court requested the taking of a vote thereon. Upon consideration of the foregoing it is

Ordered, by the Court, that the petition is denied.

Per Curiam
FOR THE COURT:
RON GARVIN, CLERK

BY:
Robert A. Bonner
Deputy Clerk

## APPENDIX E

1. Section 1862 of the Social Security Act, 42 U.S.C. 1395y(b)(2), provided in pertinent part as follows at the time of the decision below (before the amendments made by Section 151 of the Social Security Amendments Act of 1994, Pub. L. No. 103-432, 108 Stat. 4432 (signed Oct. 31, 1994)):

**§ 1395y. Exclusions from coverage and medicare as secondary payer**

**(a) Items or services specifically excluded**

* * * * *

**(b) Medicare as secondary payer**

**(1) Requirements of group health plans**

**(A) Working aged under group health plans**

**(i) In general**

A group health plan—

(I) may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(a) of this title, and

(II) shall provide that any individual age 65 or over (and the individual's spouse age 65 or older) who is covered under the plan

by virtue of the individual's current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

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**(B) Disabled individuals in large group health plans**

**(i) In general**

A large group health plan (as defined in clause (iv)) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(b) of this title.

* * * * *

**(C) Individuals with end stage renal disease**

A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is entitled to or eligible for benefits under this subchapter under section 426-1 of this title during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section

426-1 of this title, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 426-1 of this title if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from taking into account that an individual is entitled to or eligible for benefits under this subchapter under section 426-1 of this title after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and before October 1, 1998, (with respect to periods beginning on or after February 1, 1990), clauses (i) and (ii) shall be applied by substituting "18-month" for "12-month" each place it appears.

* * * * *

**(2) Medicare secondary payer**

**(A) In general**

Payment under this subchapter may not be made, except as provided in subparagraph (B),

with respect to any item or service to the extent that—

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies.

**(B) Conditional payment**

**(i) Primary plans**

Any payment under this subchapter with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this subchapter when notice or other information is received that

payment for such item or service has been or could be made under such subparagraph.

**(ii) Action by United States**

In order to recover payment under this subchapter for such an item or service, the United States may bring an action against any entity which is required or responsible under this subsection to pay with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service.

**(iii) Subrogation rights**

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

**(iv) Waiver of rights**

The Secretary may waive (in whole or in part) the provisions of this subparagraph in

the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

**(3) Enforcement**

**(A) Private cause of action**

There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with such paragraphs (1) and (2)(A).

**(B) Reference to excise tax with respect to nonconforming group health plans**

For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of Title 26.

**(C) Prohibition of financial incentives not to enroll in a group health plan**

It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this subchapter not to enroll (or to terminate enrollment) under a group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)), unless such incentive is also offered to all

individuals who are eligible for coverage under the plan. Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1320a-7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

**(4) Coordination of benefits**

Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this subchapter (without regard to deductibles and coinsurance under this subchapter) for the remainder of such charge, but—

(A) payment under this subchapter may not exceed an amount which would be payable under this subchapter for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this subchapter, when combined with the amount payable under the primary plan, may not exceed—

(i) in the case of an item or service payment for which is determined under this subchapter on the basis of reasonable cost (or other cost-related basis) or under section 1395ww of this title, the amount

which would be payable under this subchapter on such basis, and

(ii) in the case of an item or service for which payment is authorized under this subchapter on another basis—

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this subchapter (without regard to deductibles and coinsurance under this subchapter),

whichever is greater.

**(5) Identification of secondary payer situations**

**(A) Requesting matching information**

**(i) Commissioner of Social Security**

The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(*l*)(12) of Title 26) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

**(ii) Administrator**

The Administrator of the Health Care Financing Administration shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(*l*)(12) of Title 26.

**(B) Disclosure to fiscal intermediaries and carriers**

In addition to any other information provided under this subchapter to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under—

(i) subparagraph (A), and

(ii) section 1320b-14 of this title,

for purposes of carrying out this subsection.

**(C) Contacting employers**

**(i) In general**

With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of Title 26 by a qualified employer (as defined in section 6103(*l*)(12)(D)(iii) of such title), as disclosed under subparagraph (B)(i),

the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

**(ii) Employer response**

Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

**(iii) Sunset on requirement**

Clause (ii) shall not apply to inquiries made after September 30, 1998.

* * * * *

2. Section 411.24 of Title 42 of the Code of Federal Regulations provides as follows:

**§ 411.24 Recovery of conditional payments.**

If a Medicare conditional payment is made, the following rules apply:

**(a) Release of information.** The filing of a Medicare claim by on or behalf of the beneficiary constitutes an express authorization for any entity, including State Medicaid and workers' compensation agencies, and data depositories, that possesses information pertinent to the Medicare claim to release that information to HCFA. This information will be used only for Medicare claims processing and for coordination of benefits purposes.

**(b) Right to initiate recovery.** HCFA may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.

**(c) Amount of recovery.** HCFA may recover an amount equal to the Medicare payment or the amount payable by the third party, whichever is less. (The "amount payable by the third party" does not include the doubled portion of damages the third party may have paid under section 1862(b)(5) of the Act or any other punitive damages.)

**(d) Methods of recovery.** HCFA may recover by direct collection or by offset against any monies HCFA owes the entity responsible for refunding the conditional payment.

**(e) Recovery from third parties.** HCFA has a direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan, or program, and a third party administrator.

**(f) Claims filing requirements.** (1) HCFA may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services.

(2) However, HCFA will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is primary to Medicare for those particular services. (A notice received during the last three months of a year is considered received during the following year.)

**(g) Recovery from parties that receive third party payments.** HCFA has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a third party payment.

**(h) Reimbursement to Medicare.** If the beneficiary or other party receives a third party payment, the beneficiary or other party must reimburse Medicare within 60 days.

**(i) Special rules.** (1) In the case of liability insurance settlements and disputed claims under employer group health plans and no-fault insurance, the following rule applies: If Medicare is not

reimbursed as required by paragraph (h) of this section, the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.

(2) The provisions of paragraph (i)(1) of this section also apply if a third party payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment.

(3) In situations that involve procurement costs, the rule of § 411.37(b) applies.

**(j) Recovery against Medicaid agency.** If a third party payment is made to a State Medicaid agency and that agency does not reimburse Medicare, HCFA may reduce any Federal funds due the Medicaid agency (under title XIX of the Act) by an amount equal to the Medicare payment or the third party payment, whichever is less.

**(k) Recovery against Medicare contractor.** If a Medicare contractor, including an intermediary or carrier, also insures, underwrites, or administers as a third party administrator, a program or plan that is primary to Medicare, and does not reimburse Medicare, HCFA may offset the amount owed against any funds due the intermediary or carrier under title XVIII of the Act or due the contractor under the contract.

**(l) Recovery when there is failure to file a proper claim—(1) Basic rule.** If Medicare makes a conditional payment with respect to services for which the beneficiary or provider or supplier has not filed a proper claim with a third party payer, and Medicare is unable to recover from the third party payer, Medicare may recover from the beneficiary

or provider or supplier that was responsible for the failure to file a proper claim.

**(2) Exceptions:** (i) This rule does not apply in the case of liability insurance nor when failure to file a proper claim is due to mental or physical incapacity of the beneficiary.

(ii) HCFA will not recover from providers or suppliers that are in compliance with the requirements of § 489.20 of this chapter and can show that the reason they failed to file a proper claim is that the beneficiary, or someone acting on his or her behalf, failed to give, or gave erroneous, information regarding coverage that is primary to Medicare.